Financial Report

FISCAL YEAR 1995

H
Care
Financing
Administration

U.S. Department of Health and Human Services

Fiscal Year 1995
HCFA FINANCIAL REPORT

THE Chief Financial Officers Act (CFO) of 1990 (P.L. 101-576) marks a major effort to improve U.S. Government financial management and accountability. In pursuit of this goal, it instituted a new Federal financial management structure and process modeled on private sector practices. The CFO Act established in all major agencies the position of Chief Financial Officer with responsibilities including annual publication of financial statements and an accompanying report.

This Financial Report is HCFA's fourth CFO Act submission. Its form and content follow guidance provided by the Department of Health and Human Services, the Office of Management and Budget, and the General Accounting Office. It reflects HCFA's strong support of the spirit and requirements of the CFO Act and our continuing commitment to improve agency financial reporting.

U.S. Department of Health and Human Services
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244

HCFA FINANCIAL REPORT
Fiscal Year 1995

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Message from the Administrator

IN Fiscal Year 1995, the Health Care Financing Administration (HCFA) continued to carry out its basic mission of ensuring access to high quality health care for over 73 million Americans in the Medicare and Medicaid programs while at the same time streamlining and downsizing the Agency, implementing the National Performance Review, fleshing out its strategic plan, and participating in the national debates over Medicare and Medicaid reforms. FY 1995 was another busy, intense, and productive year even for HCFA.

These financial reports reflect the remarkable achievements of this Agency. Day in and day out, handling millions of health care claims, providing information to beneficiaries, monitoring the quality of care, improving policies and procedures, the talented and hard-working individuals of HCFA and HCFA's contractors carry out one of the most important and difficult tasks in government. We provided $172 billion in health benefits to 37.5 million Medicare beneficiaries while administrative expenses accounted for only 1.6 percent of the total expenses.

Prudent financial management is increasingly critical in this era of severely limited Federal resources. As an agency with one of the largest and fastest growing budgets in the Federal government, we in HCFA have a special obligation to ensure that we spend each dollar, whether for benefits or administration, as wisely as possible. The process of developing the annual financial report audited by the Office of the Inspector General of the Department of Health and Human Services helps us improve our financial management by highlighting areas requiring increased attention. For example, we are making improvements in contractor control of Medicare accounts receivable and payable.

We also work aggressively to combat and prevent fraud, waste, and abuse, and to identify inappropriate payments and recoup overpayments, while continuously improving our program oversight activities. Operation Restore Trust, an anti-fraud demonstration project run jointly with the Inspector General and other agencies, is but one example of many activities underway to improve the fiscal integrity of HCFA programs.

Our focus continues to be on providing the best possible service to our primary customers, the beneficiaries of these programs. A key element of excellence in customer service is ensuring the financial integrity and efficiency of HCFA programs and administration. I believe that these financial reports reflect our strong commitment to continuing improvement in financial management.

Bruce C. Vladeck
Administrator
April 1996

Message from the Chief Financial Officer

AS HCFA's Chief Financial Officer, I am pleased to report that in Fiscal Year 1995 we continued to make significant progress in improving financial management in HCFA in many key areas. The HCFA Strategic Plan, its goals, objectives, and related initiatives, constitutes the underpinning for the Agency's long-range planning and budget formulation.

However, while these strategies have provided a broad umbrella for Agency activities over a period of years, they do not specifically address HCFA program efforts and initiatives targeted for the current or next fiscal year. To accomplish this, during FY 1995 HCFA used the Strategic Plan as a basis for a set of core critical indicators that succinctly define our mission. We then developed a set of performance measures/indicators which could be utilized to assess whether, and how well, we were meeting these core objectives. The measures selected offer a mix of initiatives that include both broad and narrow outcomes, as well as more specific output and process measures.

This effort is just a starting point. It reflects our first step toward implementing a comprehensive program measurement and assessment system under the Government Performance and Results Act that links the Agency's organizational planning, program improvement, and fiscal year budget cycle. The next step is to evaluate the validity and reliability of the data related to each measure, assess the representative value of each measure, and then determine how the data results can or should affect HCFA program performance. Ultimately, by the end of FY 1996 we should be able to track and compare the incoming FY 1997 data to the benchmarks that were established for the measures in the FY 1996 baseline year and, through that analysis, determine our level of performance.

HCFA faces explosive growth in new providers (such as home health agencies), higher claims volume, and rapid growth in the 85 and older population, at the same time that we have to deal with FTE downsizing and limitations on discretionary spending. In order to responsibly administer programs costing $350 billion by fiscal year 1998, HCFA must alter the way it does business, by radically increasing our operating efficiency.

Protecting the solvency of the Medicare trust funds is a basic element of our mission. Program integrity activities such as payment safeguards to detect and prevent fraud and abuse have saved the Medicare trust funds approximately $17 billion over the last three years. Standardizing, consolidating, and modernizing our claims processing systems through the Medicare Transaction System (MTS) will result in annual claims processing savings when it is fully implemented. MTS will also improve services to beneficiaries and providers by supporting a single point of contact for information on entitlement, eligibility, benefits, payment decisions, and claims status. We are also working closely with Medicare contractors to encourage the development of effective management controls in their operations, and have begun the process of drafting a guide to assist contractors in reviewing their internal controls.

A major initiative launched during FY 1995 is "Operation Restore Trust," a demonstration targeting fraud and abuse in the delivery of skilled nursing facilities, home health agencies, and durable medical equipment in five States. Together with the Office of Inspector General, the Administration on Aging, the Department of Justice, and the State Medicaid fraud units, HCFA is working to identify and investigate questionable billing patterns and to develop a model for the successful prosecution of fraudulent or abusive providers or organizations.

The slowdown of the overall growth in the Medicaid program is accompanied by a gradual slowdown in the growth of enrollees receiving benefits, along with lower medical price inflation and a decrease in State expenditures. HCFA continues to foster innovation that is responsive to fiscal concerns, State and local initiatives, and the special needs of vulnerable populations. Through the use of Statewide 1115 waivers, HCFA expanded the use of managed care services to Medicaid beneficiaries in more than a dozen States, including the implementation of managed care systems in Oregon and Tennessee.

Despite the presence of many program initiatives, we have not forgotten the need to focus our attention on internal management issues. Major efforts have been undertaken during FY 1995 to provide the workforce with up-to-date technology and training to enhance the openness and frequency of communications and ensure that the workforce has appropriate information and competencies. Other activities have been initiated to enhance employee empowerment and the development of project teams. The ranks of managers have been thinned by eliminating 242 supervisory positions, 47 percent HCFA-wide, and the average number of employees per manager has increased from six to 11.

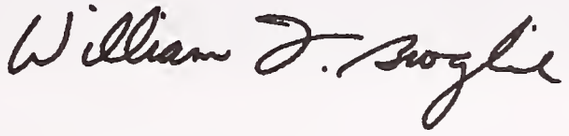
In spite of increases in program enrollment resulting in increased use of medical services and benefit claims and a proliferation of providers, HCFA has achieved efficiencies which have held Program Management spending virtually level since FY 1993.

There were also important accomplishments in the accounting area in FY 1995. HCFA successfully transferred the financial management operations of our ten regional offices to HCFA's headquarters from the DHHS, which received reimbursement for its services. The use of dual accounting systems to capture HCFA regional office financial data was eliminated with the consolidation at the HCFA site.

HCFA also mandated the use of the government purchase card for small purchases at our regional and headquarter locations. This resulted in a significant reduction in the number of vendor invoices received and processed by HCFA.

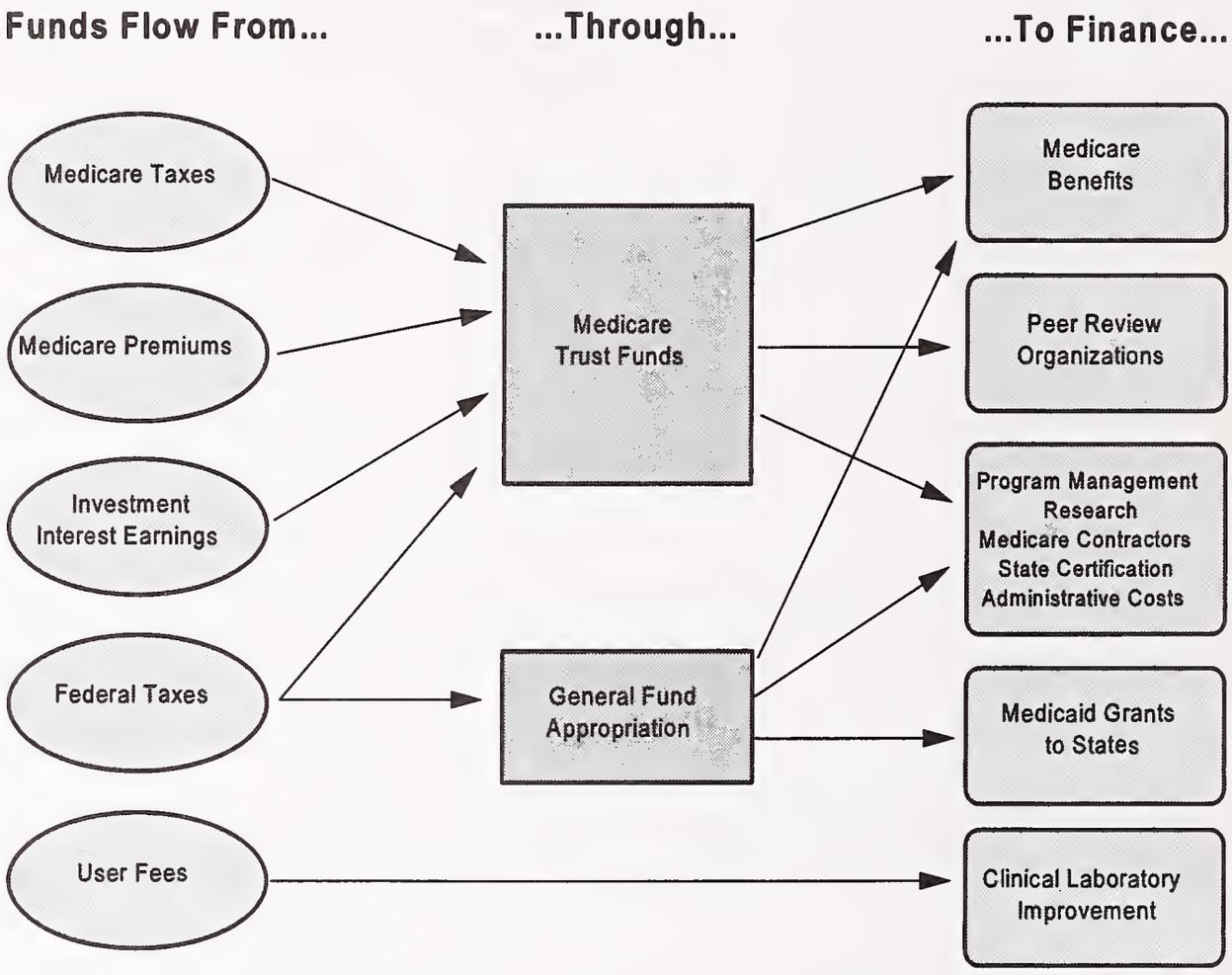
In an ongoing effort to improve Medicare financial reporting as a result of the CFO Act, HCFA planned a CFO reporting seminar with our partners in this effort, the Medicare contractors. The seminar was held in two locations and attended by more than 250 participants from the Medicare contractors and regional office staff. As a result, financial data reported by the contractors continually improves and becomes more standardized. In addition, HCFA continues to work with the design contractor of the MTS to ensure the design includes a fully integrated accounting system.

Because HCFA takes its financial management responsibilities very seriously, we continue to improve our financial systems, accounting procedures, and reporting processes to achieve our goal to have the best financial management system in Government.



William F. Broglie
Chief Financial Officer
April 1996

FINANCING OF HCFA PROGRAMS & OPERATIONS



HCFA FINANCIAL REPORT
Fiscal Year 1995

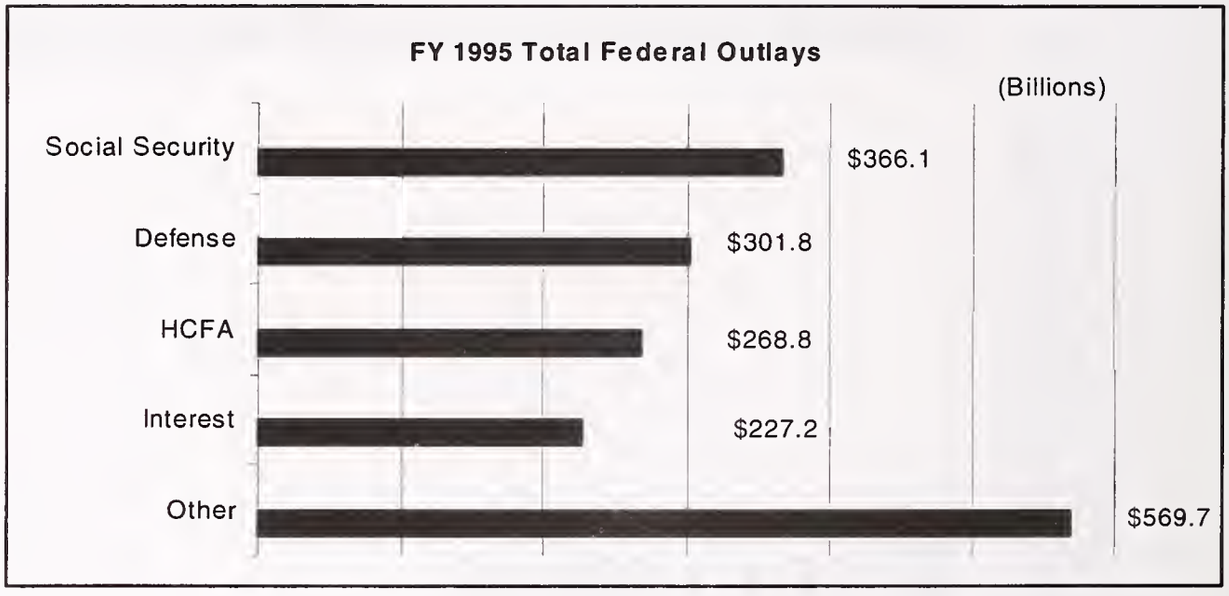
Contents

Overview

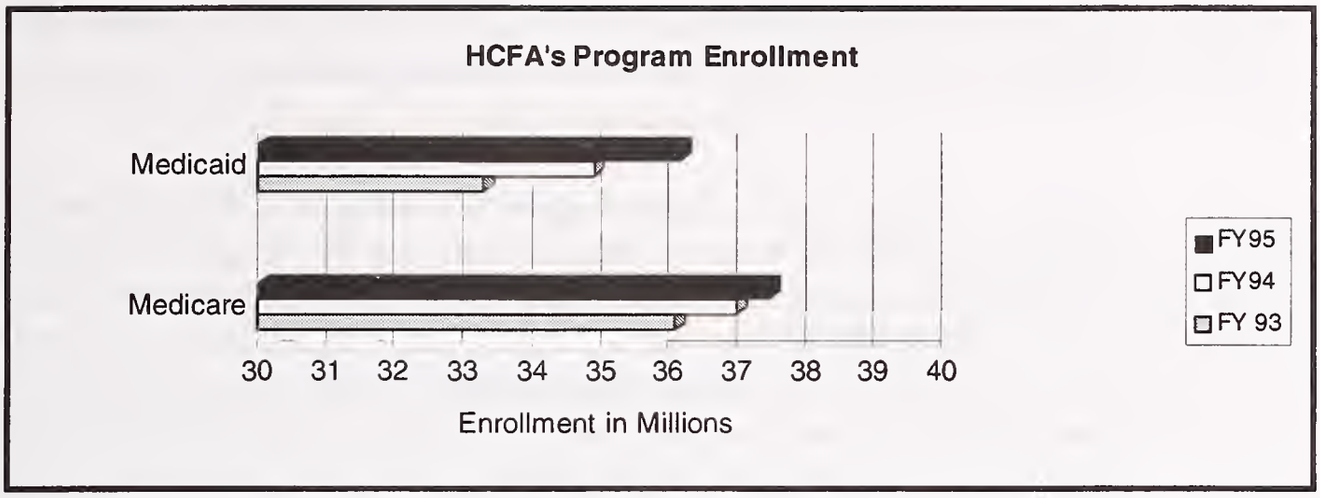
Chapter 1

EXECUTIVE SUMMARY

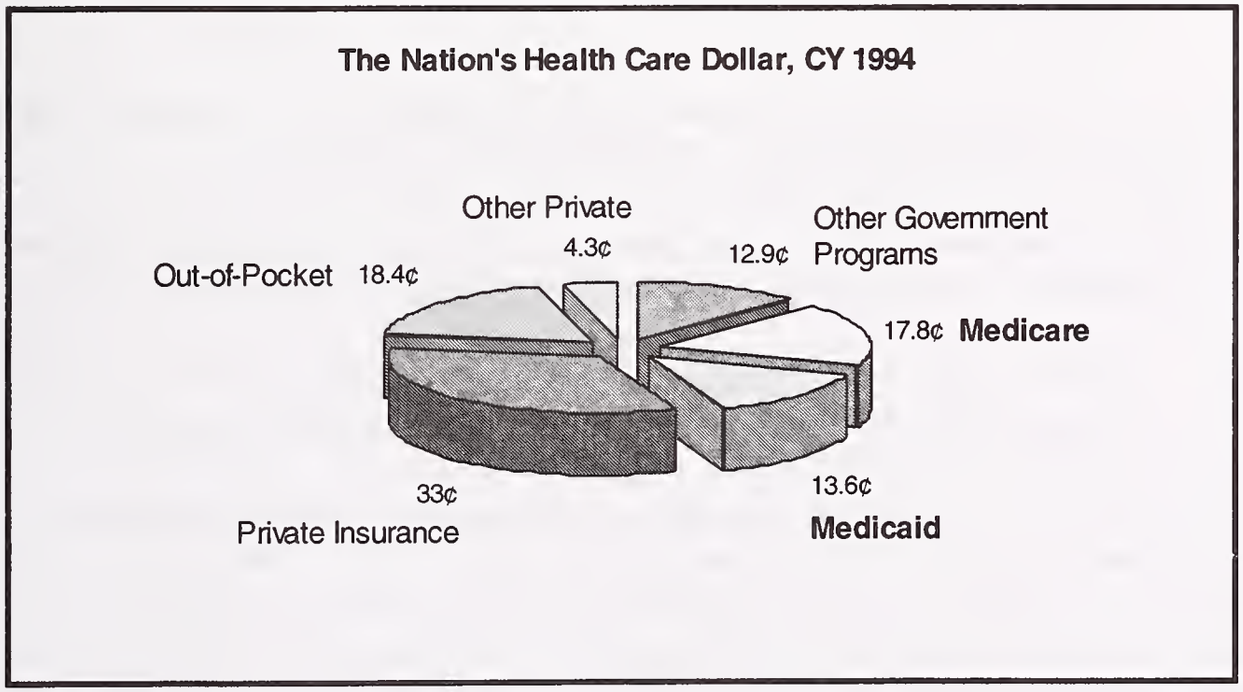
HCFA is the largest purchaser of health care in the world. HCFA and the programs it administers outlayed $268.8 billion in FY 1995. This equaled 15.5 percent of the total Federal budget, which is the third largest share of Federal spending after Social Security and Defense. Benefit and operating outlays for Medicare ($179.6 billion) and Medicaid ($89.2 billion) increased 10.1 percent from FY 1994 to FY 1995, over three times faster than the general cost of living as measured by the Consumer Price Index, and more than twice as fast as the CPI for medical goods and services. Medicare spending grew 10.8 percent and Medicaid spending rose 8.8 percent.



In FY 1995, Medicare had 37.5 million beneficiaries and the program incurred benefit and operating expenses totaling $174.5 billion for health care services for America's aged and disabled. Medicaid had 36.2 million beneficiaries and HCFA incurred Medicaid benefit and operating expenses totaling $88.1 billion for the Federal share of health care services in FY 1995. Medicare and Medicaid are administered through private contractors and State and local government agencies, respectively. HCFA provides funding, policy guidance, and quality review for the programs.



For calendar year 1994, Medicare and Medicaid outlays represented 31.4 cents of every dollar spent on health care in the United States--44.6 cents of every dollar received by U.S. hospitals and 24.1 cents of every dollar received by other health care providers. (Data for calendar year 1995 are not yet available.)



In addition to establishing rules for eligibility and benefit payments, paying 779.6 million Medicare benefits claims, and providing States with matching funds for Medicaid benefits, HCFA carries out many other important activities:

- HCFA is responsible for safeguarding the fiscal integrity of the Medicare and Medicaid programs, assuring the safety and quality of medical facilities, providers, and suppliers through setting standards, conducting inspections, and certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. HCFA also monitors the quality of care provided to Medicare beneficiaries through the Peer Review Organization (PRO) program.

- HCFA conducts an extensive program of research, demonstrations, and grants aimed at helping to improve the quality of health care, access to care, the efficiency of delivery and payment systems, and other important improvements in the health care system.

- HCFA maintains the Nation's largest collection of health care data and provides data and analytical services to the Congress, other parts of the Executive Branch, non-government analysts and researchers, as well as internal users.

- HCFA promotes managed care and assures that Federally qualified HMOs meet quality, benefit, and financial integrity standards.

- HCFA, through the Clinical Laboratory Improvement Act (CLIA) program, helps assure the quality and reliability of laboratory testing for all Americans.

- HCFA oversees State regulation of private Medigap insurance to ensure that Medicare beneficiaries are afforded important consumer protections.

To accomplish its mission, HCFA is staffed by 4,100 Federal employees, but carries out most operational activities through contractors, as follows: (1) approximately 24,000 employees at 80 claims processing contractors, which include four Durable Medical Equipment Regional Carriers; (2) 7,000 employees at 53 State survey agencies, which include surveyors, clerical, and support staff; (3) 2,200 employees at 53 Peer Review

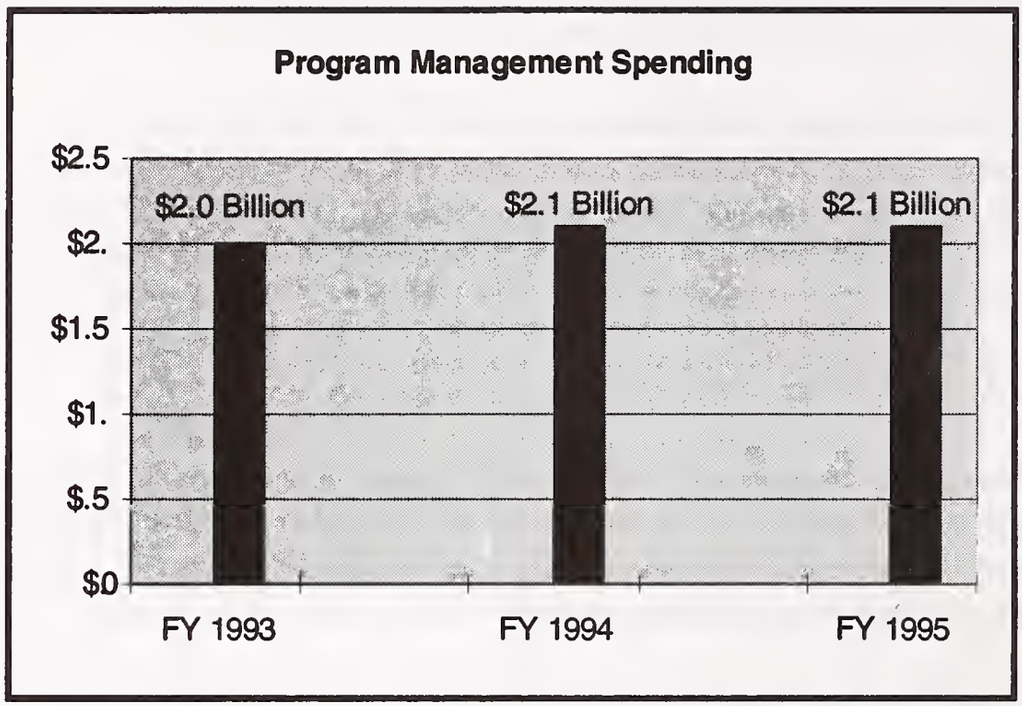
Organizations; and (4) 40,000 employees in State Medicaid agencies. The Social Security Administration and other Federal agencies also provide thousands of other staff, either full or part time, for Medicare or Medicaid operations.

Of HCFA's 4,100 full-time equivalent employees (FTEs), about 1,400 work in 10 cities around the country as the front-line people providing direct services to Medicare contractors, State agencies, providers, beneficiaries, and the general public in their areas. Approximately 2,700 of HCFA's FTEs work in Baltimore and Washington, D.C. providing funds to Medicare contractors, developing more efficient operating systems, managing programs to fight fraud, waste, and abuse, monitoring contractor performance, and assisting States with Medicaid issues.

Program Management encompasses the funding, through the annual Labor/HHS/Education Appropriations Act, of the operational and administrative expenses of Medicare, the Federal portion of Medicaid, and other agency responsibilities. There are four principal budget activities within Program Management--

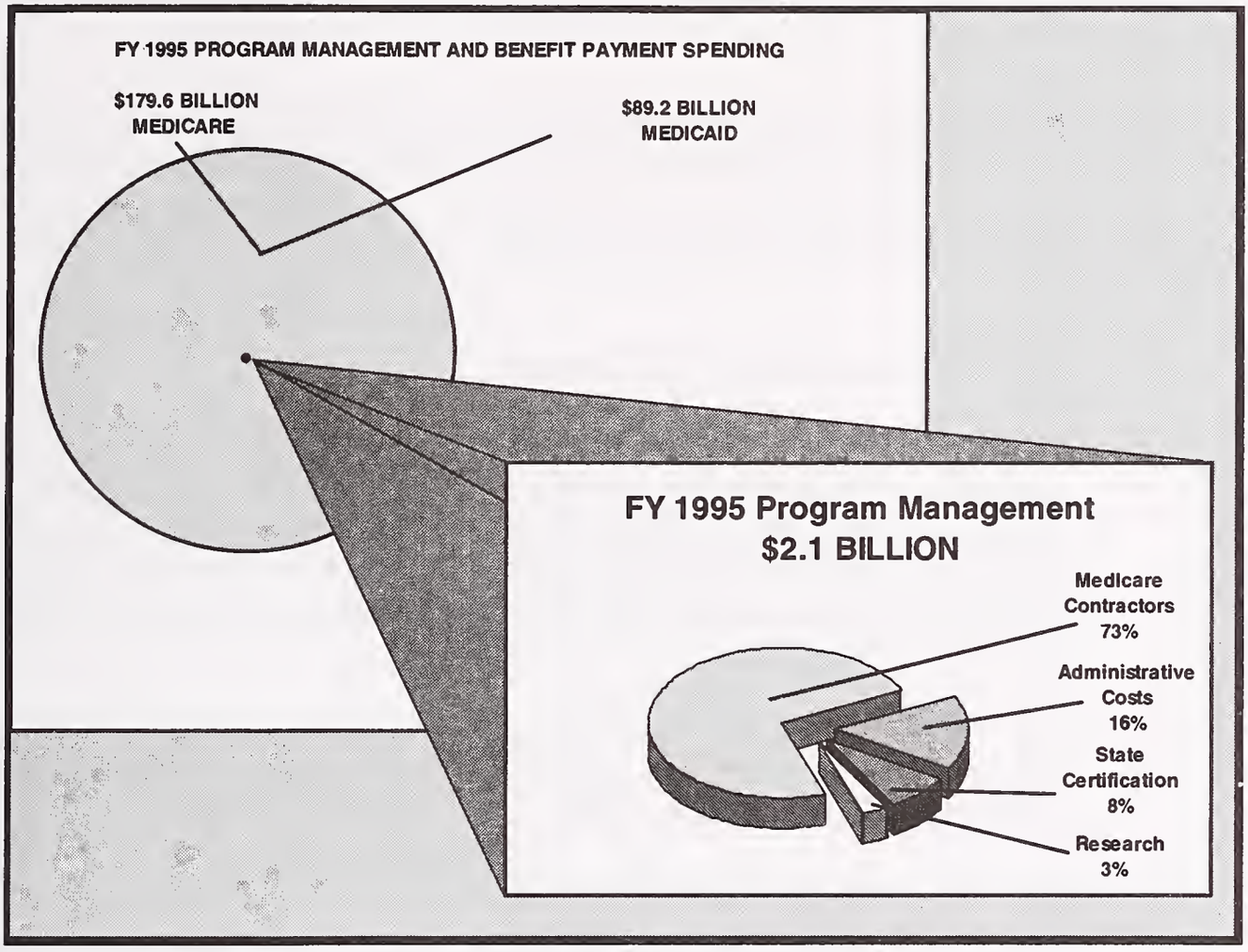
- Medicare Contractors
- Administrative Costs
- State Certification
- Research

While health care expenditures have been increasing at rapid rates, HCFA's program operating costs have actually declined after taking inflation into account. The aging of the population (resulting not only in an increase in program enrollment but also increased use of medical services and, thus, more claims for payment), increasing numbers of disabled beneficiaries, and a proliferation of providers, such as managed care networks and home health agencies, have all put tremendous pressures on HCFA's operational costs. In spite of these pressures, HCFA has achieved efficiencies which have held Program Management spending virtually level since FY 1993. Examples include reducing the costs of claims processing and quality surveys and reducing HCFA staff. Medicare Contractors account for nearly three-fourths of Program Management outlays.



HCFA's search for increased efficiency is becoming more difficult each year as our workload volumes increase and become more complex. The number of Medicare and Medicaid beneficiaries has increased by 11 percent since 1992. Over the same period, the number of home health agencies and nursing homes requiring certification has increased by 41 and 22 percent, respectively.

Recognizing the severe restraints appropriated discretionary funding will continue to face, even as mandatory entitlements such as Medicare and Medicaid expand rapidly, we are committed to a comprehensive program of productivity, service, and quality improvement.



In FY 1995, we continued to develop the HCFA strategic plan and performance measures, aggressively implemented programs to empower HCFA employees to develop process improvements, and we were active in the design phase of the Medicare Transaction System. HCFA faces increasingly difficult challenges in the years ahead and we are moving aggressively to prepare ourselves for the future.

To ensure continuous focus on improving the quality and efficiency of all aspects of HCFA's work and to prepare for future changes in the Nation's health care delivery and financing systems, HCFA is currently engaged in a comprehensive strategic planning activity that includes specific performance indicators, or critical success factors, by which progress toward achieving strategic goals can be measured. The HCFA strategic plan is discussed further in the next section of this overview.

The HCFA strategic plan will be the organizing focus for all HCFA activities, both our ongoing responsibilities and our preparations for the future. HCFA faces many important issues, and if past experience is any guide, unanticipated issues will develop which will require us to adjust and refine our plans and priorities. Some of the major issues HCFA faces include:

- Hospital Insurance Trust Fund solvency.

- Resources available for the Survey and Certification program remain constrained, but tremendous growth has occurred in the number of facilities requiring certification. Inadequate resources for this activity could endanger the health and safety of beneficiaries and limit HCFA's ability to certify new providers (adversely affecting both the providers and beneficiaries who might need them).

- The Medicare Transaction System will consolidate claims processing currently performed by 80 contractors, 10 shared systems, and over 60 processing sites into a single unified claims processing system.

- Operation Restore Trust: HCFA, along with the DHHS Office of Inspector General, the Administration on Aging, the Department of Justice, and other agencies, has undertaken this health care anti-fraud demonstration. The objective is to demonstrate a team approach in combating Medicare and Medicaid fraud, waste, and abuse associated with home health agencies, nursing homes, durable medical equipment suppliers, and hospice care. As we learn more about fraud, waste, and abuse, we are focusing our attention across the board on prevention, detection, sanctions, and prosecution.

- Enhancing beneficiary choice by expanding the participation of managed care programs in Medicare as a cost-effective alternative to fee-for-service.

- Assisting States to develop and implement Medicaid reform initiatives.

- HCFA On-Line is a comprehensive communications strategy designed to allow us to respond to customer information needs with accuracy, speed, and flexibility. Better informed beneficiaries will make better payment plan, provider, and treatment choices.

- Reducing program costs through increased fiscal reviews, third party oversight, and secondary payer activities.

Chapter 2

HCFA STRATEGIC PLAN

STRATEGIC PLAN

MISSION

We assure health care security for beneficiaries

VISION

We guarantee equal access to the best health care

GOALS

GOAL 1 - Build a high-quality, customer-focused team.

Medicare and Medicaid beneficiaries are our primary customers, and HCFA increasingly emphasizes customer service. A number of critical structural and infrastructural changes were made in 1995 to improve the effectiveness of the workforce, which, in turn, enhance our ability to best serve the Medicare and Medicaid beneficiaries. Consistent with our empowerment effort, HCFA employees at all levels now lead teams, workgroups, and projects. Consolidating HCFA's national headquarters (previously spread among 14 buildings in Baltimore and Washington) into a new facility has allowed us to exploit state-of-the-art electronic voice and data communication technologies, inciuding satellite transmission and teleproduction capabilities. We restructured our field organization to operate in "consortia" to provide better service to our beneficiaries. We have substantially streamlined a number of our internal systems and work processes, including the employees' performance appraisals, awards and merit promotion systems, as well as the small purchases process. We are continuing to explore opportunities to take advantage of automation and electronic dissemination of information, both internally and to our customers and stakeholders.

GOAL 2 - Ensure programs and services respond to the health care needs of beneficiaries.

To improve our understanding of beneficiary needs, each regional office and appropriate central office component has established a visible customer service focal point. Meeting regularly with beneficiaries and stakeholders has allowed HCFA to address their concerns and to provide information on policies, regulations, and rules. Beneficiary feedback, in fact, contributed to the design and draft of our managed care brochure explaining beneficiary choice.

HCFA, in coordination with several major groups of public and private purchasers of health care, has agreed to support the creation and efforts of the Foundation for Accountability (FACCT) to consolidate consumer and purchaser power to influence health care purchasing decisions. The Foundation's goal is to ensure that all Americans have the quality information they need to make better health care decisions in selecting their desired plans, providers, treatment methods, and lifestyles. FACCT's functions include: selecting and endorsing measures of health care quality based on the outcomes of care; employing the purchasing power of members to accelerate the adoption of measures; advocating the use of consumer-oriented measures; and educating consumers about using quality data for health care decisions.

Our HCFA On-Line initiative, developed in FY 1995, will ask beneficiaries to tell us what they want to know, how we should communicate with them, and how well we are responding to them. HCFA On-Line will create communication systems for continuous information exchange between HCFA and its customers.

The Long-Term Care initiative, also developed in FY 1995, will be beneficiary-focused. This initiative will introduce a variety of flexible long-term care delivery and payment approaches by incorporating beneficiary feedback into the creation of these new approaches.

As HCFA focuses more on the needs of its ultimate customers, HCFA and its partners must coordinate their customer service activities and share their limited resources prudently. Toward that end, a comprehensive list of all of HCFA's customer service activities was compiled into a single document, the "Project Customer." This listing (and future updates) details for all who work with the Medicare, Medicaid, and related programs the resources available to help meet our customers' needs.

GOAL 3 - Promote improved health status of beneficiaries.

HCFA is focusing on three sets of interrelated activities to promote the improved health status of beneficiaries -- beneficiary-focused outcome measures, promoting equal access to health care services, and encouraging greater use of preventive care.

HCFA is developing an Access to Care Monitoring and Evaluation System to improve access to health care services in fee-for-service and managed care settings. Under this system, Agency staff will identify and resolve, where possible, barriers to access. Through a variety of public/private partnerships, HCFA is also engaged in many projects to improve the quality of health care services provided to Medicare beneficiaries in a variety of settings. HCFA is working with Peer Review Organizations, End Stage Renal Disease (ESRD) Networks, State Survey Agencies, and many other organizations to implement programs and improve care for patients with acute myocardial infarction, diabetes, ESRD, and other conditions.

The Health Care Quality Improvement Program (HCQIP) emphasizes continual quality improvement of health care. The Peer Review Organizations (PRO) program, which is the focal point of the HCQIP, has now evolved into a proactive effort that develops and promotes best practice guidelines, utilizing an educational approach in partnership with the health care community.

Furthermore, HCFA has launched a major project to develop and implement valid and reliable measures of improved outcomes and satisfaction for beneficiaries in nursing homes and home health agencies. New, patient-centered, outcome-oriented regulations that include a central focus on quality assessment and performance improvement programs are nearing completion, and new surveyor processes that focus on the actual experiences of beneficiaries have been implemented in nursing homes, home health agencies, dialysis facilities, and facilities for persons with mental retardation. And there is strong evidence that the use of educational approaches in the clinical laboratory program has greatly improved the performance of laboratory testing by physician office laboratories.

As part of HCFA's Consumer Information Program, we completed a national campaign promoting influenza shots for Medicare beneficiaries prior to the 1995 flu season. HCFA is currently running a major national promotional campaign for mammograms as part of the fight against breast cancer. We are also running, in partnership with the Centers for Disease Control and Prevention, a Flu 2000 campaign to help achieve the goal of a 60 percent flu immunization rate for Medicare beneficiaries by the year 2000. In addition, HCFA has undertaken the Horizons Project, a collaboration between HCFA and historically black colleges and universities in the Southeast, to develop and implement community-level intervention strategies to improve the health status of African-American Medicare beneficiaries, with initial focus on the use of flu shots.

Because HCFA, along with our partners, has focused its efforts on appropriate care and services for nursing home residents, the proportion of physically restrained residents has been reduced from 40 percent to 20 percent. The inappropriate use of antipsychotic drugs in nursing homes has also declined 59 percent.

In 1995, HCFA worked with the National Committee for Quality Assurance (NCQA) and other key partners to apply the private sector's state-of-the-art HMO performance measurement system--NCQA's Health Plan/Employer Data and Information Set--to the Medicare and Medicaid programs.

GOAL 4 - Be a leader in health care information resources management.

HCFA's databases are the Nation's largest and most complete source of health care information. HCFA maintains data on health care utilization for over 73 million Medicare and Medicaid beneficiaries, covering a wide range of hospital and physician services, delivery arrangements, and consumer demographics. Accordingly, we emphasize that these data resources are used effectively to improve programs and operations, ensure quality of care, and enable providers and beneficiaries to make informed treatment choices.

HCFA works with the PROs to obtain outcome data to conduct analyses of practice patterns that are subsequently shared with the health care community to improve the quality of care received by beneficiaries. Other data improvement activities include our national provider identifier project, State Medicaid research files, fraud and abuse data initiatives, Medicare Secondary Payer settlement systems, the premium collection system, and the Medicare Current Beneficiary Survey.

HCFA also responds to an increasing number of data requests from internal and external sources. We provide direct access to over 9,000 users, including Medicare contractors, State agencies, and PROs. Annually, HCFA answers about 500 requests for public use files, 7,000 Medicare inquiries, 300 requests for custom data files, 1,800 requests for Medicaid data, and 200 requests for epidemiological data. Other requests come from the Congress, 20 Federal agencies, researchers, beneficiary groups, provider groups, insurance companies, and the news media.

GOAL 5 - Promote fiscal integrity of HCFA programs.

HCFA faces explosive growth in new providers (especially home health agencies), in higher claims volume, and in the rapid growth of the 85 and older population--all of this, while we must cope with FTE downsizing and limitations on our discretionary spending. Therefore, in order to responsibly administer programs projected to cost $350 billion by fiscal year 1998, HCFA must alter the way it does business, by significantly increasing our operating efficiency.

Together with the Office of Inspector General, the Administration on Aging, the Department of Justice, and the State Medicaid fraud units, HCFA launched "Operation Restore Trust," a demonstration targeting fraud and abuse in the delivery of skilled nursing facilities, home health agencies, and durable medical equipment in five States. Members of this group work in concert identifying and investigating questionable billing patterns and developing a model for the successful prosecution of fraudulent or abusive providers or organizations. A national on-line database was developed containing detailed information on all Medicare fraud investigations.

HCFA also established a Medicaid Fraud and Abuse Network to develop a "best practices" package by pooling the collective resources of central and regional offices. This package will be distributed throughout the Medicaid community.

HCFA implemented a new intermediary audit process that significantly reduces administrative burdens and maximizes the use of available audit resources in settling provider cost reports. Additionally, HCFA implemented a modified system for tracking intern and resident FTEs to ensure that Medicare payments for direct and indirect medical education are proper. Similarly, HCFA instructed physicians as to the correct use of procedure codes (which identify physician evaluation and management services), thereby assuring consistency in billing and medical review. Data systems have been and will continue to be developed to ensure that the limited health care funds available are being spent appropriately.

GOAL 6 - Create excellence in the design and administration of our programs.

This goal echoes many of the themes of "reinventing government" and requires that HCFA take actions necessary to improve and streamline our own administrative processes, which also impact on our contractors.

The Medicare Transaction System (MTS) is a major advancement in the processing of claims and in the gathering of related information. This system is designed to integrate, standardize, and significantly improve the efficiency of processing Medicare claims. MTS will consolidate the claims processing function currently performed by 80 contractors, 10 shared systems, and more than 60 processing sites into one Federally-owned system--a system that HCFA will own and control, but one that the Medicare contractors will operate. MTS will improve services to beneficiaries and providers by establishing a single point of reference for information on entitlement, eligibility, benefits, payment decisions, and claims status. Its development has progressed with the Operating Capability document which describes the functions that MTS will support through September 1999. This document is being shared with the design contractor, GTE Government systems, the Medicare contractors, and central and regional office staff for review and comment. The document also contains the MTS future business requirements that, along with the current MTS requirements, will become the MTS baseline.

The contractor performance evaluation process was converted from a "snapshot rating program" to an ongoing process for continuous improvement. This new approach helps the Agency make contract management decisions by providing a more comprehensive, meaningful, and up-to-date picture of contractor performance. Its strategy is the product of regional and central office collaboration, the empowering of the regions to focus on known/perceived areas of difficulty in contractor performance, of interactions with customers, and of reinforcing contractor responsibility for acceptable performance of all provisions of the contract.

GOAL 7 - Provide leadership in the continuing evolution of the health care system.

HCFA continues to foster innovative demonstrations and research addressing fiscal concerns, State and local initiatives, and the special needs of vulnerable populations. Through Statewide 1115 demonstration waivers, HCFA expanded the use of managed care services by Medicaid beneficiaries in more than a dozen States (including the highly publicized managed care systems in Oregon and Tennessee). These efforts provided coverage to approximately 8 million persons, many of whom were previously uninsured. The 1115 waivers allow States to test new approaches to their Medicaid programs by granting flexibility from Federal Medicaid statutory and regulatory requirements.

Likewise, HCFA has designed a number of important demonstration and research projects which attempt to anticipate future health systems needs. Among the more prominent projects: (1) Medicare Choices Demonstration, designed to provide Medicare beneficiaries with a broad range of managed care health plan options; (2) Participating Centers of Excellence Demonstration, an effort designed to bundle physician and hospital services into a single package price for major heart and orthopedic procedures; and (3) the Health Status Registry, which permits HCFA to monitor the health status and utilization of Medicare services.

In addition, HCFA has implemented studies examining the viability and cost-effectiveness of health care in specialized areas. Key areas of investigation: (1) rural areas of Telemedicine and (2) Medicaid and health care policy research of Medicaid-eligible populations, including low-income pregnant women and children and the disabled. Identifying the types of information that Medicare and Medicaid beneficiaries and pre-retirees would find most useful in selecting health insurance plans, providers, and practitioners is another research project.

PERFORMANCE MEASURES

TO address HCFA program efforts and initiatives targeted for the current or next fiscal year, we initiated a process of further defining and synthesizing our Strategic Plan into four core critical indicators that succinctly define our mission. After identifying the critical elements of our mission, we then sought to develop a set of performance indicators and measures which could be utilized to assess how well we were accomplishing these core objectives.

The indicators/measures selected offer a mix of initiatives that include both broad and narrow outcomes, as well as more specific output and process measures. Also, where a direct causal relationship between the event(s) being measured and HCFA program activities could not be established, indicators were utilized. Indicators are included because, although their outcomes are not solely or directly attributable to HCFA actions, they can point to trends that may influence HCFA program decisions. In other instances, where no specific measurable data was available, substitute "proxy" measures were identified for development.

The following is a list of HCFA's core indicators and selected examples of the many measures identified for each indicator.

1. **Improving the health status of Medicare and Medicaid beneficiaries by making sure that they have access to and receive quality care.**

    - o Decreasing hospital mortality rate among Medicare beneficiaries due to acute myocardial infarction.

2. **Ensuring that the information needs of Medicare and Medicaid beneficiaries are met so that they can make more informed choices in health care and delivery systems.**

   - o Increase the proportion of Medicare beneficiaries who are highly satisfied with their choice of health plans and the information available to them to make choices.

3. **Meeting our financial stewardship responsibility by maximizing operational performance in HCFA and our agents and ensuring that we maintain the public trust.**

   - o Reduce the amount of Medicare overpayments.

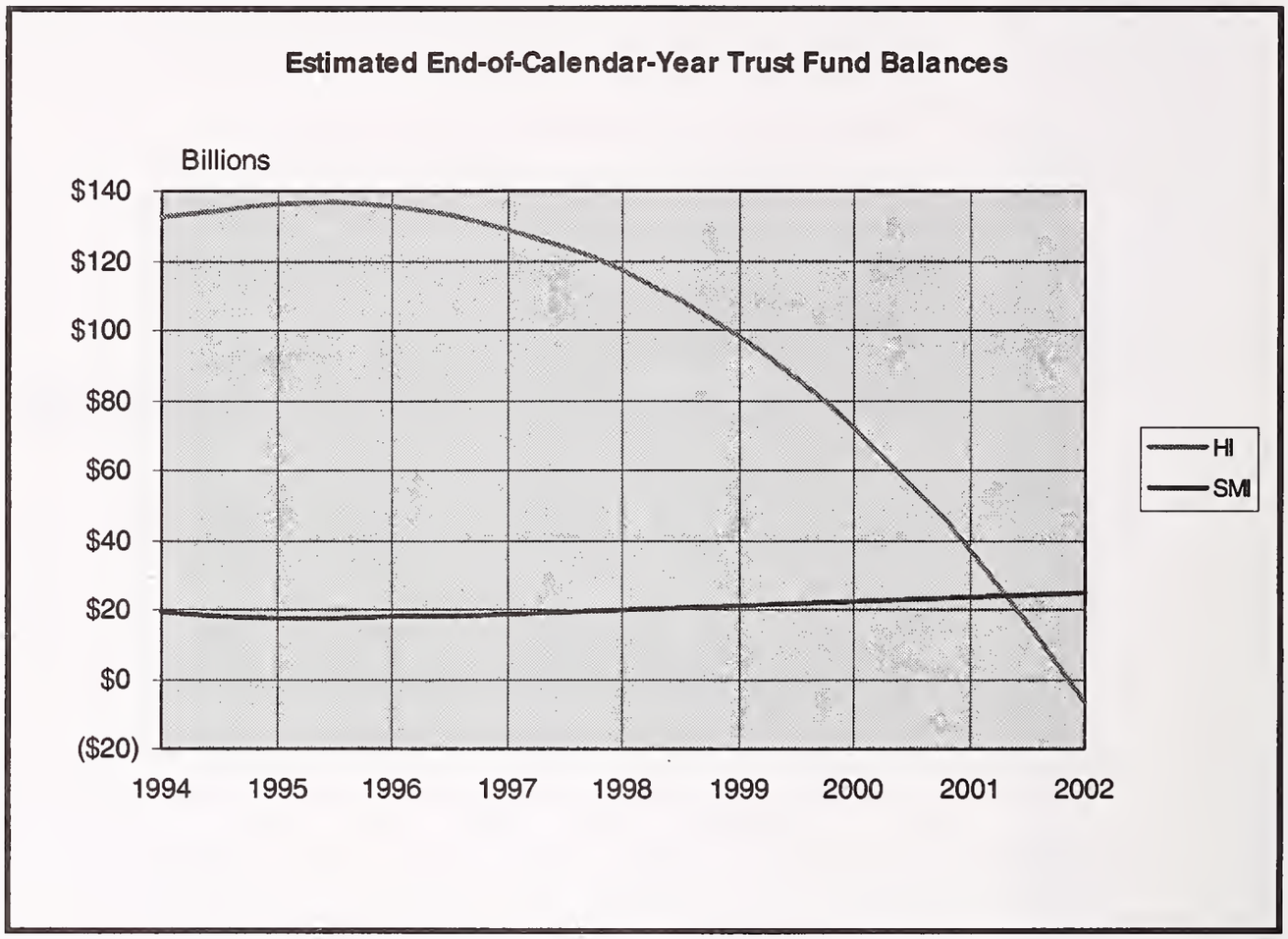
4. **Ensuring that our workforce is technically competent, customer focused, and service oriented.**

   - o Improvements in organizational structure, training, and workplace culture to enhance customer service, customer focus, and efficiency.

This effort is just a starting point. It reflects our first step toward implementing a comprehensive performance measurement and assessment system under the Government Performance and Results Act. The next step is to evaluate the validity and reliability of the data related to each of the indicators or measures, assess and analyze the representative value of each measure, and then determine how the data results can or should affect HCFA performance.

Chapter 3

MEDICARE

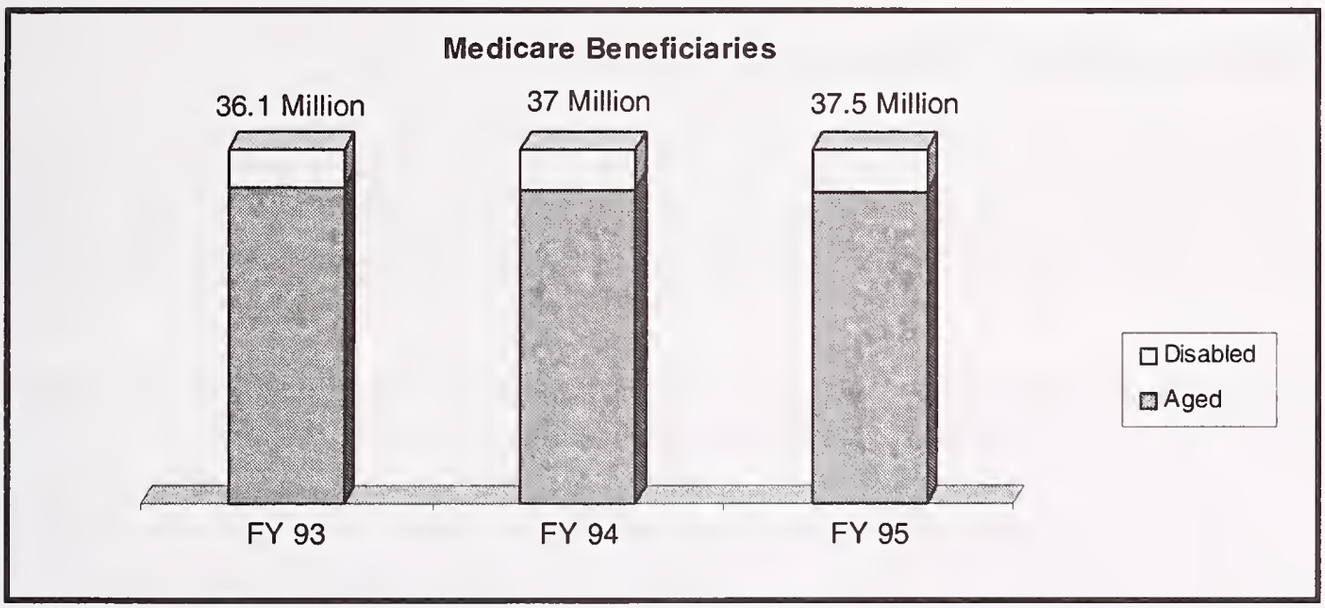


Key Fact

The 1995 Trustees Report of the Hospital Insurance Trust Fund projected depletion of the fund in 2002. Later information published in the 1996 Trustees Report will be reflected in the Financial Report for FY 1996.

PROGRAM PROFILE

Title XVIII of the Social Security Act was established by the Social Security Amendments of 1965. Legislated as a complement to Social Security retirement, survivors, and disability benefits, Medicare originally covered people aged 65 and over. Since 1966, when Medicare was implemented, the program has been broadened to cover the disabled, people with end-stage renal disease, and certain others who elect to purchase Medicare coverage.



Medicare is a combination of two programs, each with its own enrollment, coverage, and financing--Hospital Insurance and Supplementary Medical Insurance.

Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is generally provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. HI pays participating hospitals, skilled nursing facilities, home health agencies, and hospice providers for covered services rendered to Part A enrollees.

Part A is financed through the HI Trust Fund, whose revenues come primarily through Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). In 1995, the Medicare payroll tax rate was 2.9 percent of annual wages--all employees and employers were each required to contribute 1.45 percent of employees' wages, with no limitation, to the HI Trust Fund. The self-employed paid the full 2.9 percent.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over and disabled people entitled to Part A. SMI covers physician and outpatient care, laboratory tests, durable medical equipment, designated therapy services, and other services not covered by HI.

SMI coverage is optional and subject to monthly premium payments by beneficiaries. About 95 percent of HI enrollees elect to enroll in SMI.

The 1995 SMI premium, set by statute, was $46.10 per month. In FY 1995, beneficiary premiums accounted for 34.2 percent of SMI revenues. The remainder was provided by appropriated Federal general revenues.

FY 1995 HIGHLIGHTS

Status of the Trust Funds

The 1995 Report of the HI Board of Trustees projected, under intermediate actuarial assumptions, that the HI Trust Fund will be depleted in 2002. The Trustees (the Secretaries of the Treasury, Health and Human Services, Labor, and two public trustees) recommended that legislative action be taken to bring the HI program into actuarial balance.

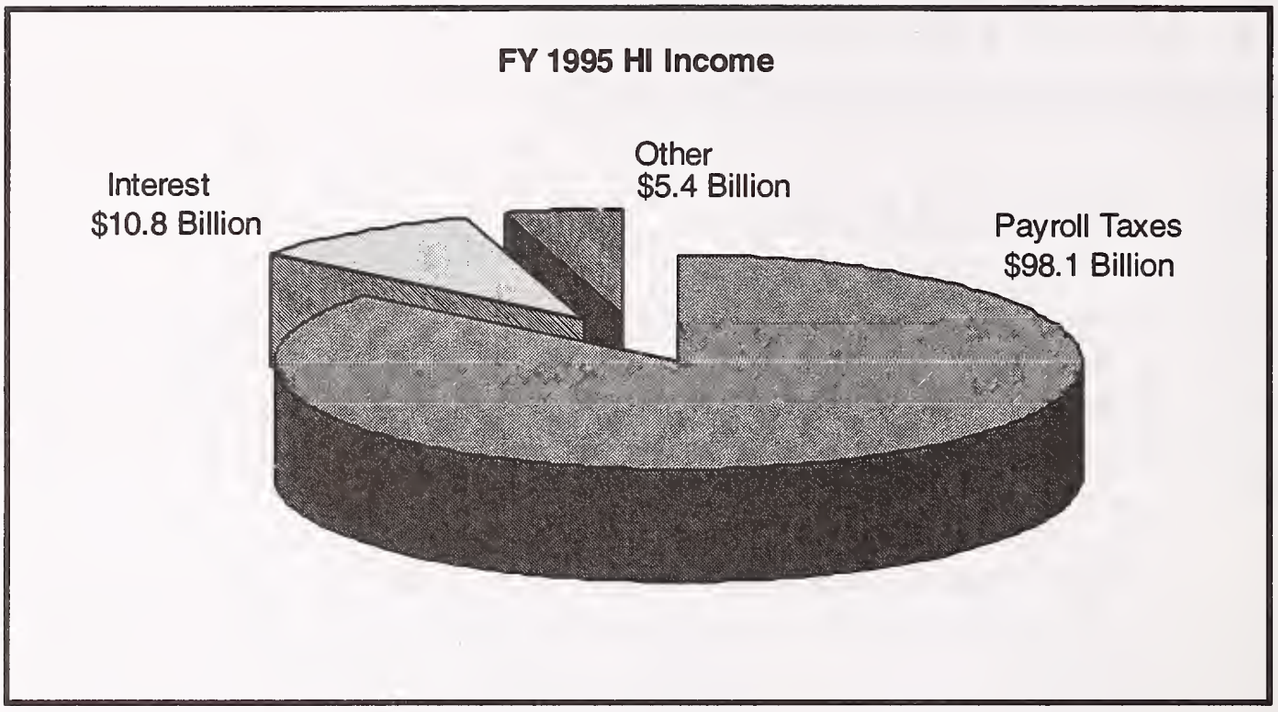
As discussed in Note 1, HCFA's basis of accounting for the Medicare program includes both the cash and accrual methods. Amounts published in the Final Monthly Treasury Statement of Receipts and Outlays of the United States Government for Fiscal Year 1995 show only the cash receipts and outlays of the HI Trust Fund. Final cash receipts were $36 million less than cash outlays. On the other hand, these financial statements incorporate actual premiums and interest collected and benefits disbursed with accrued Interest Income on Investments and Benefit Payment expense. As a result, these statements report a $2.8 billion excess of revenues and other financing sources over total expenses of the HI Trust Fund.

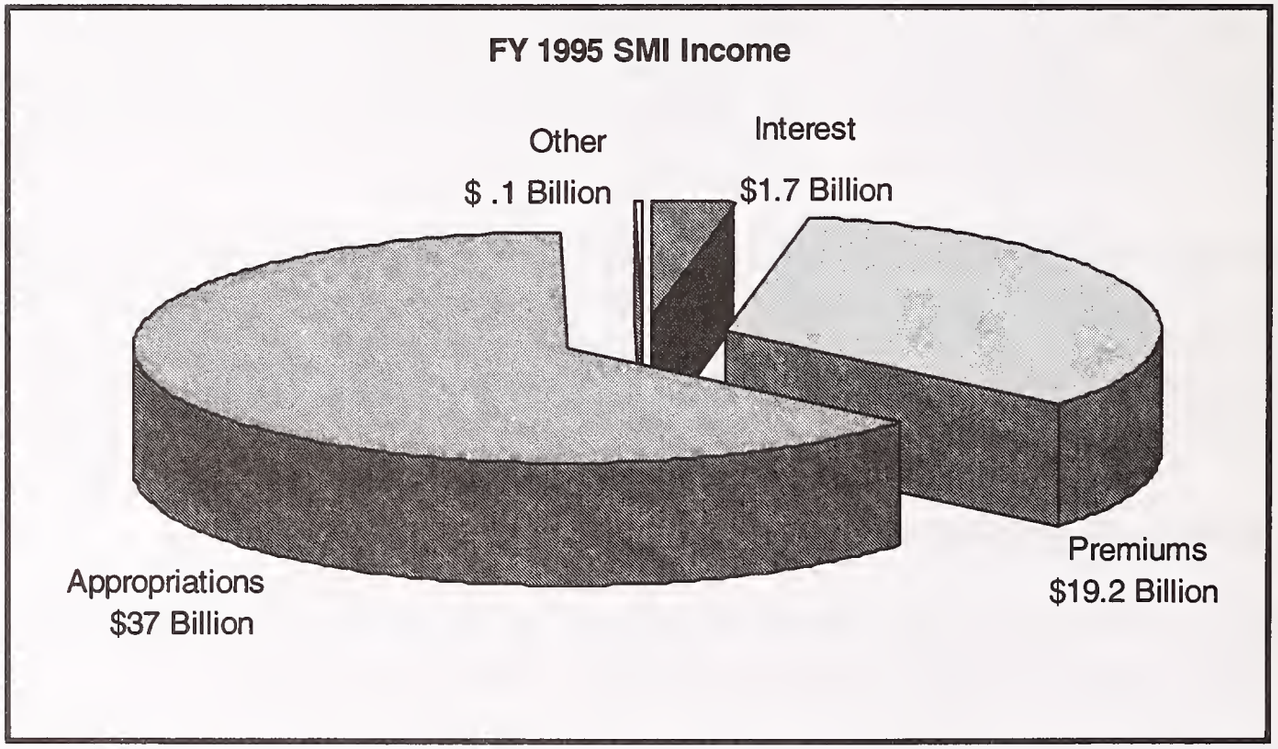
Unlike HI, which is financed primarily by payroll tax revenues based on statutory provisions covering several years, most current SMI costs are financed on a current-year basis through appropriations of Federal general revenues and beneficiary premiums. The SMI Board of Trustees reported that the SMI program is actuarially sound, but noted that the rapid rate of program outlay growth requires legislative action to control SMI costs.

Trust Fund Income

Medicare trust fund income totaled $172.3 billion in FY 1995, a 5.9 percent increase over FY 1994, compared with the 10.8 percent increase in Medicare outlays.

HI Trust Fund income was $114.3 billion, 8.5 percent more than in FY 1994. SMI income increased 1.2 percent to $58 billion.

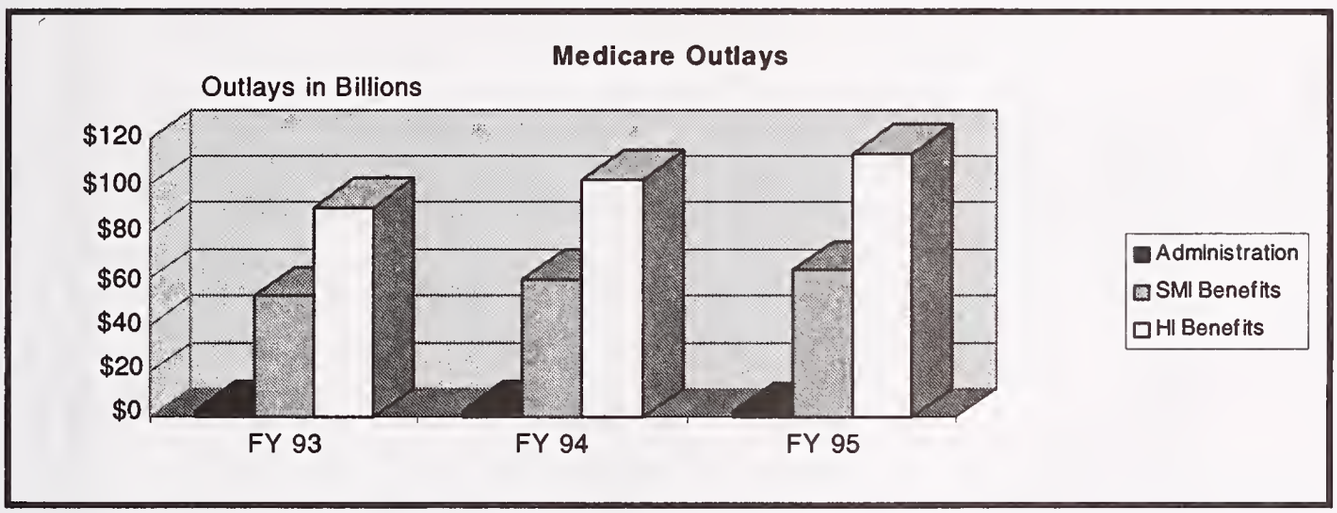

FY 1995 HI Income
Interest
$10.8 Billion
Other
$5.4 Billion
Payroll Taxes
$98.1 Billion


FY 1995 SMI Income
Other
$ .1 Billion
Interest
$1.7 Billion
Appropriations
$37 Billion
Premiums
$19.2 Billion

Trust Fund Outlays

Total Medicare outlays, including benefit payments, Peer Review Organization spending, and administrative costs, increased 10.8 percent over FY 1994. HI Trust Fund outlays were $114.4 billion in FY 1995, 11.7 percent more than in FY 1994. SMI outlays rose 9.2 percent to $65.2 billion.

Both the HI and SMI Trust Fund income to outgo ratios decreased in FY 1995. The HI Trust Fund ratio decreased three percent, taking in one dollar for each dollar outlayed. The SMI Trust Fund ratio decreased seven percent, taking in 89 cents for each dollar outlayed.



Medicare Benefit Payments

Benefit payments accounted for about 98.5 percent of the total $179.6 billion in outlays. HI benefit payments ($113.4 billion) rose 11.9 percent; SMI benefits ($63.5 billion) rose 9.5 percent.

Inpatient hospital services now account for about 77 percent of HI benefits. Hospital payment growth was driven by both increased hospital admissions and higher costs per admission. Spending for skilled nursing facility care, home health care, and hospice care continued to rise at a much faster rate, but these services constitute a much smaller portion of total HI outlays.

Inpatient hospital spending accounted for more than 50 percent of the $12 billion increase in HI benefits. Home health spending comprised only 13.1 percent of total spending but 24 percent of the FY 1995 increase.

SMI benefits grew at a more modest 9.5 percent, but still far outpaced general inflation. Physician services, the largest component of SMI spending, grew 8.3 percent and accounted for more than 56 percent of the $5.5 billion increase in FY 1995 SMI benefits.

MEDICARE BENEFIT OUTLAYS

(Dollars in Millions)	FY 1993	FY 1994	FY 1995
HI:			
Inpatient Hospital	$75,020	$80,866	$87,512
Skilled Nursing Facility	5,027	7,116	9,142
Home Health	9,529	12,005	14,895
Hospice	958	1,363	1,854
Total	90,534	101,350	113,403
SMI:			
Physician	33,803	37,282	40,376
Outpatient	11,916	13,155	14,576
Group Practice	4,550	5,464	6,297
Independent Lab	2,031	1,958	2,067
Other	101	137	166
Total	52,401	57,996	63,482
Total Benefit Outlays	**$142,935**	**$159,346**	**$176,885**

Though only constituting 23 percent of SMI benefits, payments for outpatient services accounted for nearly 26 percent of FY 1995 SMI growth.

HI benefits per enrollee rose 7.1 percent to $2,993. However, less than 22 percent of HI enrollees received benefits in FY 1995--thus, spending per enrollee receiving services was

much higher: $13,948. SMI benefits per enrollee increased 9.5 percent to $1,815. Spending per enrollee receiving services was $2,163.

Medicare Administrative Expenses

HCFA's total administrative expenses were $2.83 billion in FY 1995, a 2.5 percent increase over FY 1994 administrative expenses. Of this amount, total Medicare administrative expenses in FY 1995 were $2.71 billion: 72.6 percent for HCFA Program Management, 20.4 percent for Social Security Administration and other Federal agencies providing Medicare program support, and 7 percent for Peer Review Organizations.

Peer Review Organizations (PROs)

The PRO program, initiated in 1984, is the primary Federal effort to monitor the quality of care provided to Medicare beneficiaries. The program's mission is to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

In FY 1995, HCFA administered 53 PRO contracts: one per State, the District of Columbia, the Virgin Islands, and Puerto Rico.

Under Federal budget rules, the PRO program is defined as "mandatory" rather than "discretionary" because, like Medicare benefits, PRO costs are financed directly from the trust funds and are not subject to the annual appropriations process. PRO Trust Fund outlays in FY 1995 totaled $190 million, $5 million or 2.6 percent less than in FY 1994. The decrease in PRO outlays is largely attributable to implementation of the new Health Care Quality Improvement Program (HCQIP) Scope of Work in PRO contracts.

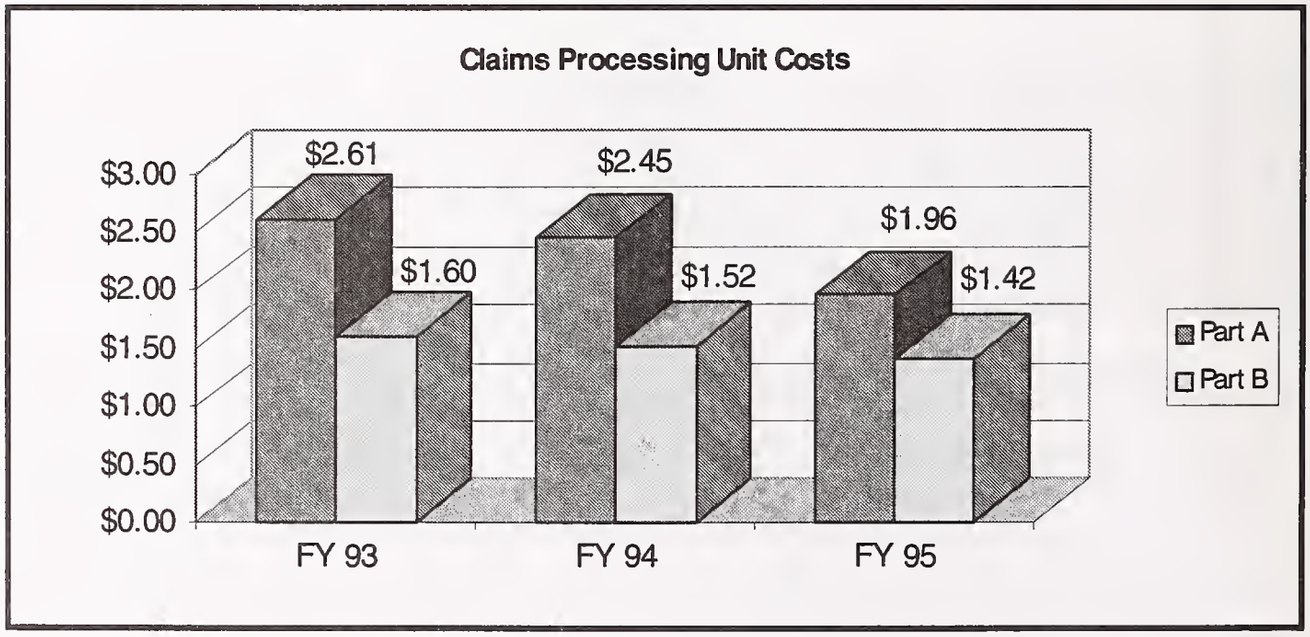
Through this HCQIP approach, HCFA has re-engineered the PRO program to better meet the goal of improving the health status of Medicare beneficiaries by promoting the delivery of high quality, effective and efficient health services. HCQIP relies on provider-based quality improvement, a data-driven external monitoring system based on quality indicators, and sharing of comparative data and best practices with providers to stimulate

improvement. Working together as partners, PROs, ESRD Networks, and health care providers utilize Continuous Quality Improvement techniques to measurably improve processes of care.

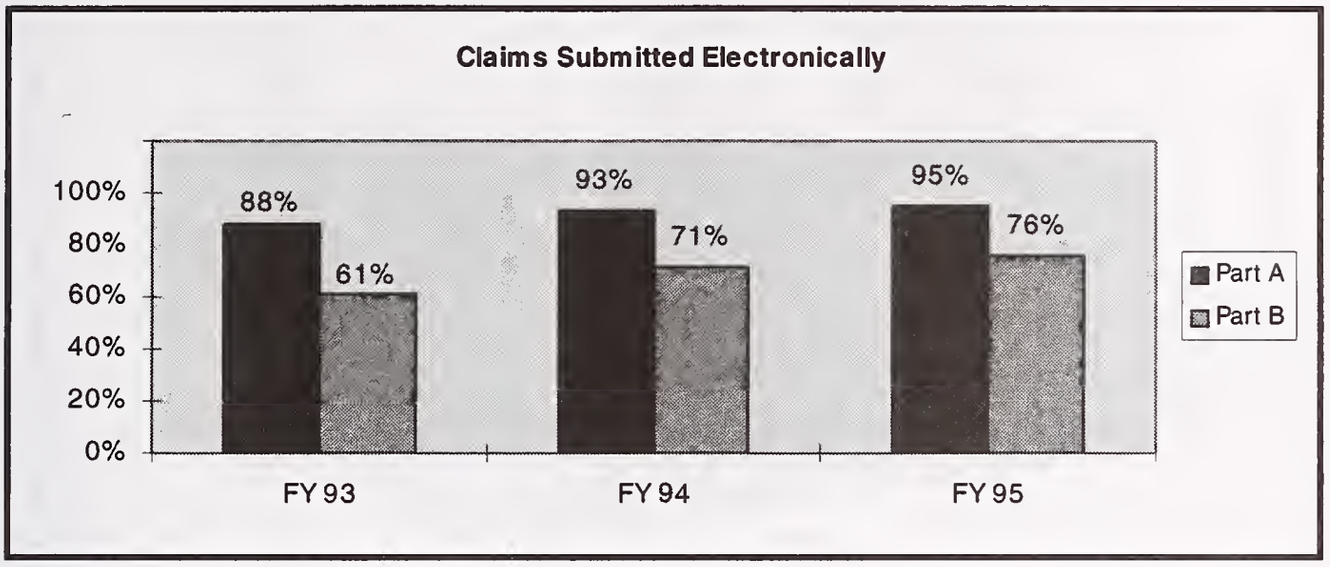
Program Management

Eighty HCFA contractors provided local administration of the Medicare program in FY 1995. **Medicare contractors** process and pay benefit claims, respond to beneficiary and provider inquiries, review claims for medical necessity and indications of fraud and abuse, audit providers, conduct hearings and appeals, and perform other claims-related work. There are 46 fiscal intermediaries handling HI (and some SMI) and 34 carriers handling SMI. While Medicare contractor administrative outlays held steady at $1.5 billion in FY 1995, the processed workload for Part A bills increased by 10 percent and by 5 percent for Part B claims.

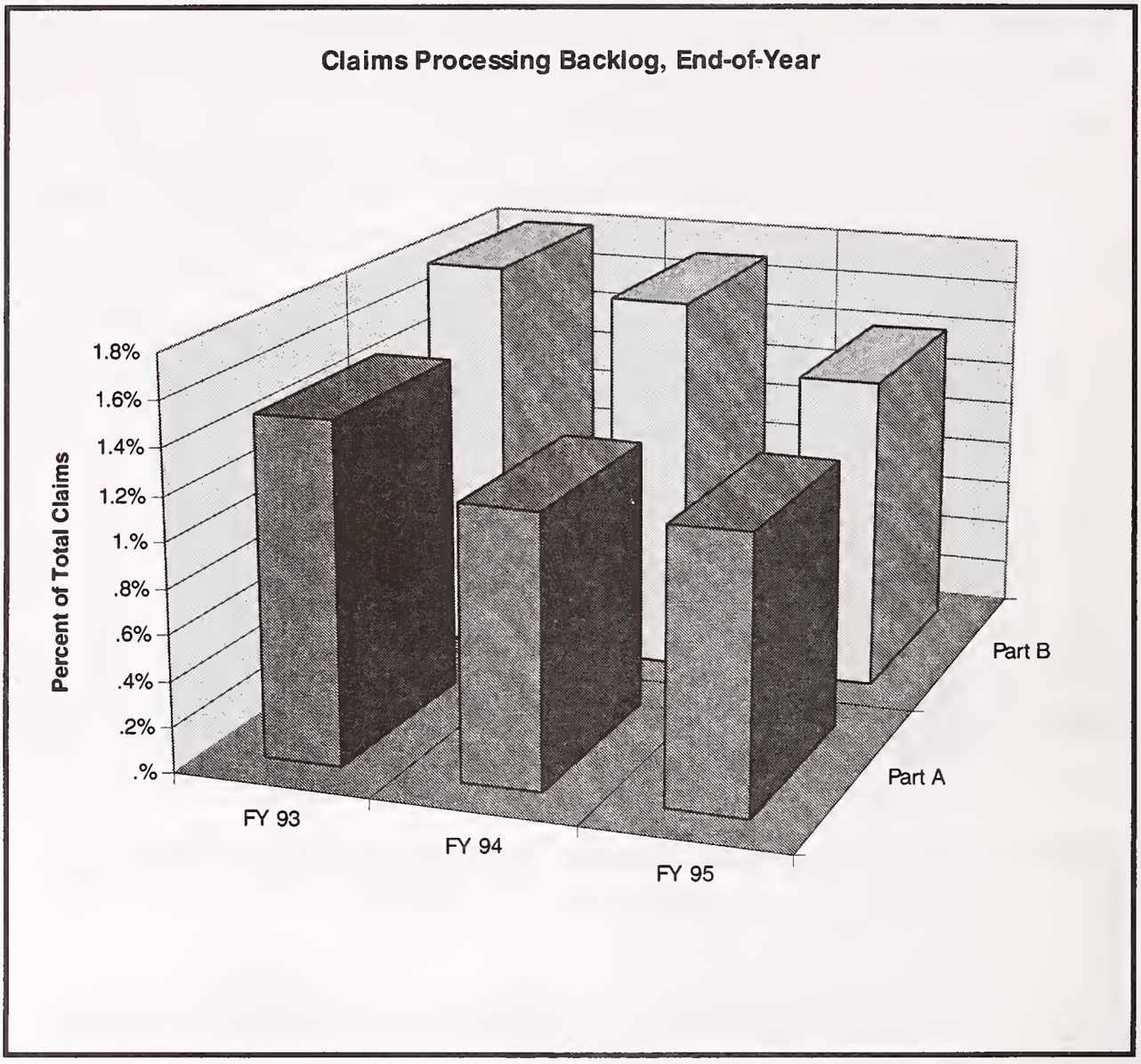
HCFA continued to bridge the growing gap between workload and contractor funding through unit cost reduction. Contract negotiations, special initiatives, and contractor evaluation policies stressed the importance of lowering unit costs in individual contracts and reducing variation among contractors.



In FY 1995, the results of an earlier industrial engineering (IE) study were no longer used. The use of the IE over the last three fiscal years enabled HCFA to successfully achieve its goals of improving efficiency in contractor operations and reducing contractor-by-contractor cost inequities, thus achieving lower unit costs. Since these goals have been achieved and costs are controlled, each contractor's FY 1995 unit cost was based on its FY 1994 level. Also, the continued use of electronic claims submission has enabled HCFA to reduce unit costs overall.



As claims processing costs decreased, the FY 1995 end-of-year pending as a percent of claims remained constant at 1.2 percent for Part A and decreased from 1.7 to 1.4 percent for Part B.

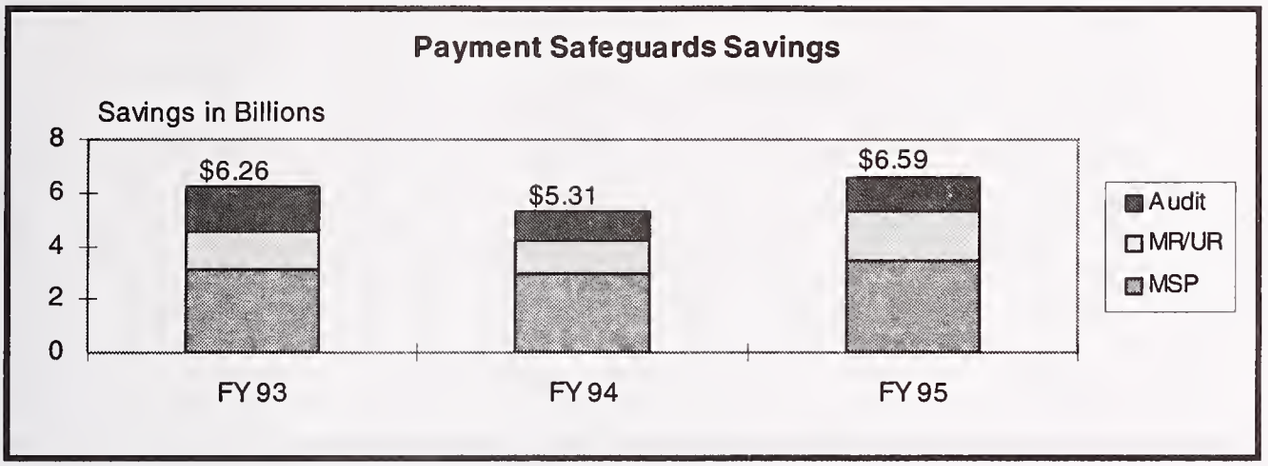


The Medicare contractors carry out a range of activities collectively known as "payment safeguards" to prevent, detect, and recover inappropriate Medicare benefit payments. Over the past several years, these payments have returned significant savings to the trust funds. Payment safeguards include:

- Medicare Secondary Payer (MSP)--activities that identify instances where an insurance company may be the primary payer, prior to payment of the claim by Medicare or as a recovery after payment by Medicare,

- Medical Review and Utilization Review (MR/UR)--activities that ensure medical services provided are covered by Medicare and are necessary and appropriate,
- Audits of Medicare providers, and
- Fraud and abuse detection and prevention.

The magnitude of Medicare payment safeguard savings illustrates that funding of payment safeguards is a sound investment. Each appropriated payment safeguard dollar leads to savings of many more benefit dollars.



In addition to payment safeguards, HCFA invested $59.1 million in Medicare Contractor productivity investments. These include projects targeted toward administrative simplification as well as initiatives that sustained activities directly in support of the transition to the Medicare Transaction System, such as:

- Efforts to fund software development,
- Efforts to consolidate the Shared Claims Processing Systems, and
- Efforts to strengthen data analysis, particularly in the areas of fraud and abuse.

The mission of the **State Survey and Certification** program is to ensure that Medicare service providers and suppliers comply with Federal health, safety, and program standards. To meet this goal, HCFA administers agreements with State survey agencies to conduct onsite facility inspections. Only certified providers and suppliers are eligible for Medicare payments. A companion Medicaid State certification program is funded through the Medicaid appropriation. Total outlays in FY 1995 were $139 million. State surveyors conducted 26,690 inspections and found 20,426 facilities cited for deficiencies.

MEDICARE STATE CERTIFICATION, FY 1995

	Facilities	Surveys	Coverage
SNF (Medicare Only)	1,253	1,161	93%
SNF (Medicare/Medicaid)	12,057	11,631	96%
Hospital (Non-Accredited)	1,407	329	23%
Hospital (Accredited)	4,958	1,155	23%
Home Health Agency	9,074	8,838	97%
ESRD Facility	2,861	636	22%
Hospice	1,887	397	21%
Other	7,971	2,543	32%
Total	**41,468**	**26,690**	**64%**

Chapter 4

MEDICAID

PROGRAM PROFILE

Medicaid is the means-tested health care program for low-income Americans, administered in partnership by States and the Federal government. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to welfare recipients. Over the years, however, Congress incrementally expanded Medicaid well beyond the traditional welfare population. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including--

- poor families,
- the blind and disabled, and
- low-income elderly, disabled, and mentally retarded persons requiring long-term care.

One U.S. citizen in eight was covered by Medicaid in fiscal year 1995.

Under Medicaid's division of responsibilities, HCFA provides matching payment grants to State governments.

- State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 1995, the Federal matching rate ranged from 50 to 79 percent, with a national average of 57 percent.
- Federal matching rates for various State and local administrative costs are set by statute, and in 1995 averaged 56 percent.

Medicaid grants are funded by Federal general revenues provided to HCFA through the annual Labor/HHS/Education Appropriations Act. There is no cap on Federal matching payments to States.

States set eligibility, coverage, and payment standards within broad Federal guidelines that include:

- Providing coverage to persons receiving Aid to Families with Dependent Children (AFDC) and Supplemental Security Income, to the medically needy, to pregnant women, to young children, to low-income Medicare beneficiaries, and to certain other groups; and

- Covering 13 mandatory services, including hospital treatment, laboratory tests, family planning, nursing facility services, and health screening for children under age 21.

State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual State circumstances and priorities. Accordingly, there is a wide variation in the services offered by States. For example, 28 State Medicaid programs cover psychologist services, 51 cover dental services, and 16 cover services provided in Christian Science sanitoria.

Medicaid helps reduce infant mortality and improve maternal and infant health by bringing more eligible pregnant women into risk-specific health care and more infants into early health supervision. States can pursue these goals by expanding eligibility, streamlining eligibility processes, conducting outreach, improving provider recruitment and retention, and adding new service delivery options or enhancements.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a preventive and comprehensive health program for Medicaid-eligible individuals under the age of 21. It creates a conceptual framework under which Medicaid-eligible children can receive regular preventive health screenings and a range of follow-up services that may be broader than those available to Medicaid-eligible adults.

Medicaid serves at least 40 percent of all persons living with AIDS and up to 90 percent of all children with AIDS, and is the largest single payer of direct medical services for persons living with AIDS. Most adults with AIDS or HIV-related illnesses who qualify for Medicaid do so because they are disabled, have low income, and/or have limited assets. Women and children living with AIDS who are not considered disabled may qualify for Medicaid if they receive cash benefits under AFDC or may qualify as an impoverished pregnant woman or child.

FY1995 HIGHLIGHTS

Outlays

The Medicaid program has experienced stabilized growth for the past two years. This is due in part to several interacting factors:

- a steady rate of health care inflation, lower than experienced in fiscal years 1991 through 1993,
- slower growth in the number of Medicaid enrollees receiving services,
- an absence of new Federal mandates,
- movement of the States toward managed care and other types of utilization management, and
- a stabilized economy.

MEDICAID OUTLAYS

(Dollars in Millions)	FY 1993	FY 1994	FY 1995
Federal Outlays:			
Medical Assistance	$72,791	$78,763	$85,379
Administration	2,983	3,271	3,691 *
Total Federal	75,774	82,034	89,070
State Outlays:			
Medical Assistance	53,802	58,638	64,407
Administration	2,199	2,532	2,925
Total State	56,001	61,170	67,332
Total Outlays	**$131,775**	**$143,204**	**$156,402**

* Does not include $118 million in outlays for HCFA Program Management costs

Continued limits on the ability of States to use tax and donation arrangements to leverage Medicaid funding and limits on disproportionate share hospital expenditures have also helped to stabilize overall Medicaid growth.

Medicaid outlays reflect cash disbursements by State and Federal governments. In FY 1995, Federal Medicaid matching outlays increased by 8.6 percent to $89.1 billion. Another $.1 billion was outlayed for HCFA Program Management of the Medicaid program. The States outlayed $67.3 billion, bringing total Medicaid outlays to $156.4 billion, 9.2 percent more than in FY 1994.

Under Medicaid, State payments for both medical assistance (MA) and administrative (ADM) costs are matched with Federal funds. In FY 1995, State and Federal ADM outlays were $6.6 billion--only 4.2 percent of the total Medicaid outlays. State and Federal MA outlays were $149.8 billion, or 95.8 percent of total Medicaid outlays, an increase of 9 percent over FY 1994.

Medical Assistance Expenditures

After the end of each fiscal quarter, States report total expenditures under the Medicaid program to HCFA. HCFA performs a review of expenditures for allowable costs and

MEDICAID MEDICAL ASSISTANCE BY SERVICE

(Dollars in Billions)	FY 1993	FY 1994	FY 1995
Inpatient Hospital	$39.6	$39.5	$42.1
Mental Health Facility	5	5.8	6.6
Nursing Facility	26.1	28.1	30.5
ICF/MR	9.3	9.2	9.5
Presciption Drugs	6.9	7.5	8.4
Physician	7.4	7.6	7.6
Health Insurance	7.8	10.5	14.1
Outpatient Hospital	6.3	6.5	6.7
Home Health/Personal Care/ HCBW/Community	6.8	8.5	9.6
Clinic	2.7	2.9	3.2
Other	8	11.5	13.8
Total Expenditures Reported by the States	**$125.9**	**$137.6**	**$152.1**
Total Medical Assistance Outlays	**$126.6**	**$137.4**	**$149.8**

continually makes expenditure adjustments even after the fiscal year ends. Preliminary MA expenditures reported by the States for FY 1995 were $152.1 billion--$2.3 billion more than MA outlays. The preliminary MA expenditure reports showed an increase in inpatient hospital charges of 6.6 percent over FY 1994 expenditures and accounted for 27.7 percent of FY 1995 expenditures. Health insurance payments, comprised primarily of Medicaid managed care insurance premiums, accounted for 9.3 percent of MA expenditures, an increase of 34.3 percent over FY 1994. The rapid increase in expenditures for health insurance payments reflects the shifting of costs from fee-for-service to managed care arrangements.

Medicaid Enrollees

In FY 1995, an estimated 36.2 million Medicaid enrollees received services--an increase of 3.1 percent over FY 1994. Children comprised 48.3 percent of Medicaid enrollees receiving services, but accounted for only 15 percent of Medicaid outlays. In contrast, the elderly and disabled comprised 27.9 percent of Medicaid enrollees receiving services, but accounted for 60 percent of program spending.

MEDICAID ENROLLEES

(Persons in Millions)	FY 1993	FY 1994	FY 1995
Needy Adults	7.5	7.6	7.8
Needy Children	16.3	17.2	17.5
Disabled	5.0	5.5	6.0
Elderly	3.9	4.0	4.1
Other	0.7	0.8	0.8
Total	**33.4**	**35.1**	**36.2**

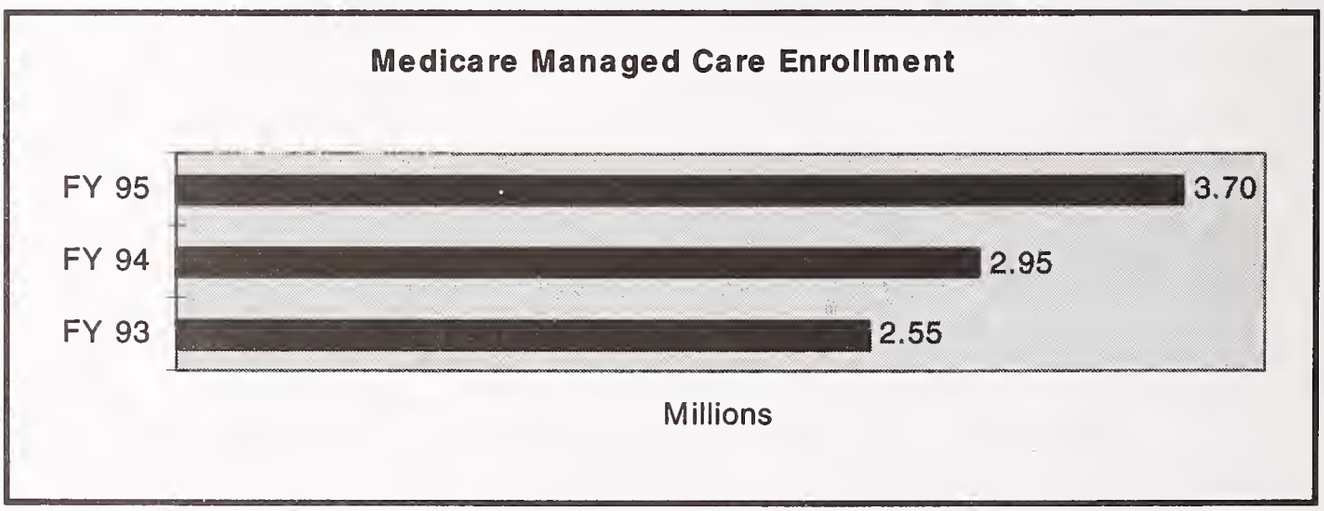
Chapter 5

MANAGED CARE

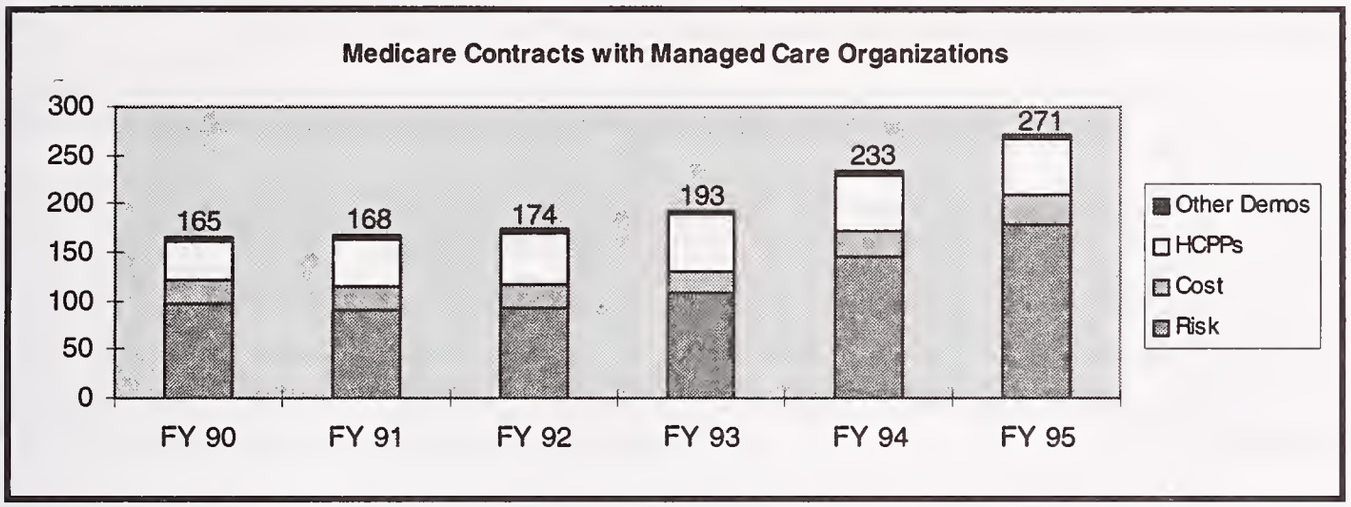
PROGRAM PROFILE

In general, a managed care organization consists of its own providers or a network of health care providers (physicians, hospitals, skilled nursing facilities, etc.) that agrees to arrange for health care services for its members. Any individual (Medicare-covered or non-Medicare-eligible) can join a managed care organization. To become a member of a managed care organization, an individual must agree to conform with the plan's rules, and depending upon the insurance coverage contracted for, the individual may be required to pay certain deductibles or co-payment amounts.

At present, HCFA contracts with Health Maintenance Organizations (HMOs), Competitive Medical Plans (CMPs), Health Care Prepayment Plans (HCPPs), and certain demonstration projects as Medicare managed care organizations. In addition, Preferred Provider Organizations (PPOs) and point-of-sale organizations are included under the umbrella of managed care organizations by the health care industry. Many people find that managed care organizations provide additional services/benefits at little or no additional cost. Because HCFA pays most premiums for beneficiaries who choose to use managed care organizations, medical expenses are more predictable and additional beneficiary out-of-pocket expenses are kept to a minimum.



Medicare managed care is growing. An increasing number of people coming into the Medicare program are choosing managed care. Since FY 1992, the number of Medicare enrollees in managed care plans has increased by 61 percent. HCFA has also seen an increased interest from health care entities in contracting with HCFA for the delivery of Medicare managed care services. This trend is evident as the number of Medicare contracts with managed care organizations has increased from 165 in FY 1990 to 271 contracts in FY 1995.



Managed care outlays accounted for $14.1 billion of the total $176.9 billion in Medicare benefit payments in FY 1995. The growth of Medicare managed care creates new challenges for HCFA, particularly in the areas of enforcement activities (including investigations, intermediate sanctions, and civil monetary penalties) and quality assurance.

Medicaid Managed Care: Program Profile

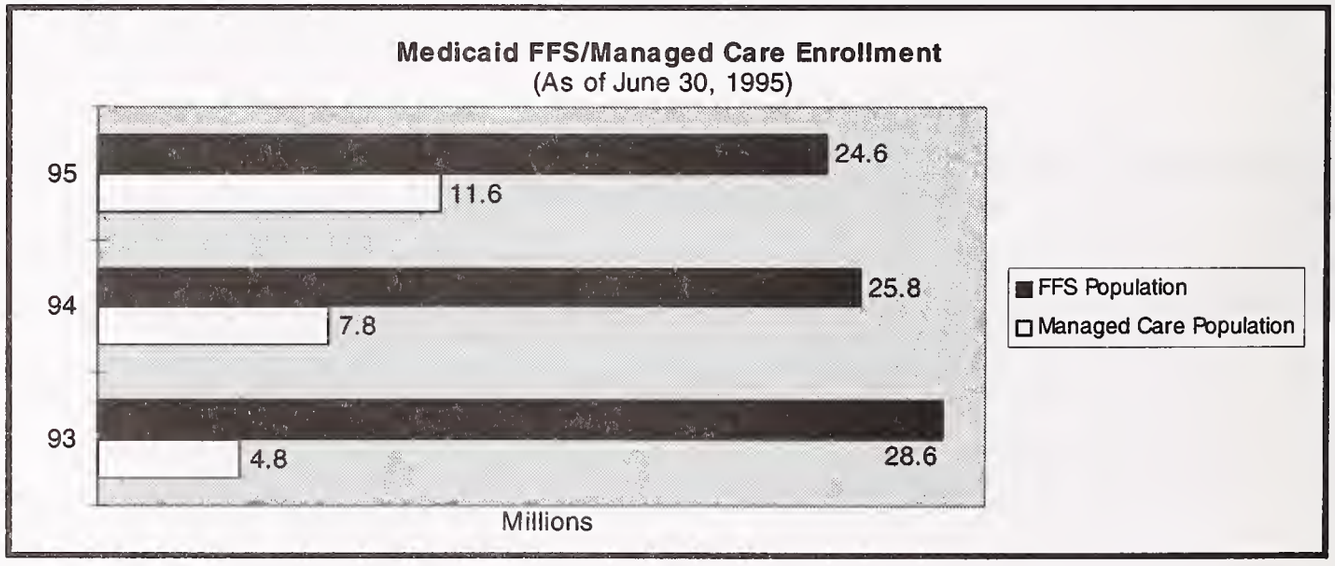
Many States are pursuing managed care as an alternative to the fee-for-service (FFS) system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications.

HCFA and the States have worked in partnership to offer managed care to Medicaid beneficiaries. Medicaid law provides for two kinds of waivers of existing Federal statutes to allow for the implementation of managed care--

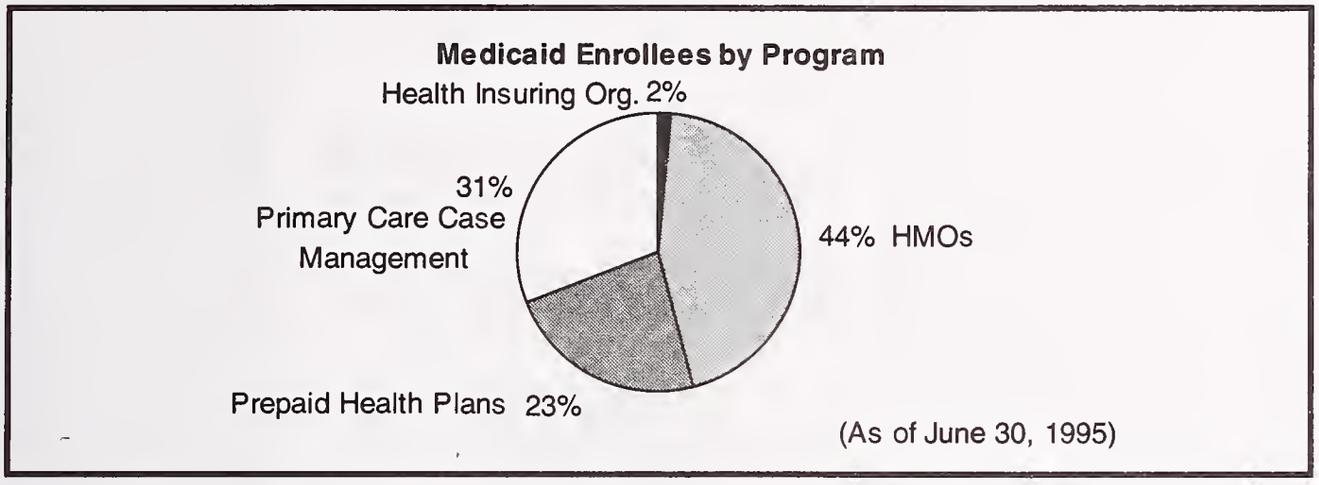
1) State health reform waivers (section 1115 of the Social Security Act) and

2) Freedom of choice waivers (section 1915(b) of the Social Security Act).

In 1995, seven 1115 demonstration waivers and thirty-nine 1915(b) freedom of choice waivers (new and renewal) were approved. There were also nineteen 1915(b) waiver modifications approved and twenty-eight additional 1915(b) waivers with approval pending in 1995.



As of June 30, 1995, 46 States had managed care available through contracts with HMOs, prepaid health plans, primary care case managers, and/or health insuring organizations.



The number of Medicaid beneficiaries enrolled in managed care grew 67 percent from 1994 to 1995. In 1995, approximately 30 percent of all Medicaid beneficiaries were enrolled in managed care.

Quality Performance Standards

While managed care programs have been successful in many States, the programs have presented new challenges to HCFA and the States, especially in areas of quality and data collection. In 1995, HCFA made significant progress toward meeting these challenges. HCFA's quality improvement strategy includes streamlining standards, developing meaningful information on quality for the purpose of program monitoring, consumer information, and continuous quality improvement by providers of care.

In 1995, HCFA laid groundwork for development of unified Medicare and Medicaid Quality Improvement Standards for Managed Care. The new standards build upon Medicaid Quality Assurance Reform Initiative guidelines and various Medicare and Federal qualification manual, policy, and related requirements. The unified standards for Medicare and Medicaid will stress measurable quality improvement.

HCFA is committed to streamlining the quality improvement standards for Medicare and Medicaid managed care. HCFA will continue to work with the States to identify and collect meaningful data and to use it to monitor performance of managed care programs.

FINANCIAL STATEMENTS & NOTES

COMBINED STATEMENT OF FINANCIAL POSITION
AS OF SEPTEMBER 30, 1995 AND 1994

(Dollars in Millions)

	FY 1995	FY 1994 Restated
ASSETS		
Entity Assets:		
Intragovernmental Assets:		
Fund Balances *(Note 2)*	$25,370	$27,289
Accounts Receivable, Net	3	1
Governmental Assets:		
Accounts Receivable, Net *(Note 3)*	2,973	2,538
Advances and Prepayments	337	336
Property and Equipment, Net	55	26
Total Entity Assets	**28,738**	**30,190**
Non-Entity Assets:		
Intragovernmental Assets:		
Fund Balances *(Note 2)*		917
Interest Receivable	2,885	3,107
Investments *(Note 4)*	143,378	150,204
Governmental Assets:		
Accounts Receivable, Net *(Note 3)*	491	480
Total Non-Entity Assets	**146,754**	**154,708**
TOTAL ASSETS	**$175,492**	**$184,898**
LIABILITIES		
Liabilities Covered by Budgetary Resources:		
Intragovernmental Liabilities:		
Accounts Payable *(Note 5)*	$18	$29
Liabilities for Loan Guarantees	9	28
Governmental Liabilities:		
Accounts Payable *(Note 5)*	23,580	27,589
Suspense Accounts Deposit Funds	1	2
Interest Payable		1
Accrued Payroll and Benefits	10	6
Other Governmental Liabilities *(Note 6)*	351	299
Total Liabilities Covered by Budgetary Resources	**23,969**	**27,954**
Liabilities Not Covered by Budgetary Resources:		
Intragovernmental Liabilities:		
Accounts Payable	6	6
Uncollected Revenue due Treasury *(Note 6)*	123	159
Governmental Liabilities:		
Accrued Leave	20	18
Other Governmental Liabilities *(Note 6)*	317	179
Total Liabilities Not Covered by Budgetary Resources	**466**	**362**
TOTAL LIABILITIES	**$24,435**	**$28,316**
NET POSITION *(Note 7)*		
Balances:		
Unexpended Appropriations	$151,345	$156,759
Invested Capital	55	26
Less: Future Funding Requirements	343	203
TOTAL NET POSITION	**151,057**	**156,582**
TOTAL LIABILITIES & NET POSITION	**$175,492**	**$184,898**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF OPERATIONS AND CHANGES IN NET POSITION FOR THE PERIOD ENDING SEPTEMBER 30, 1995 AND 1994

	(Dollars in Millions)	
	FY 1995	**FY 1994 Restated**
REVENUE AND FINANCING SOURCES		
Direct Appropriations Expended	$88,017	$86,670
Employment Tax Revenue *(Note 8)*	98,054	92,027
SMI Premiums Collected *(Note 9)*	19,243	16,894
Federal Matching Contributions *(Note 9)*	36,988	38,355
Revenue From Sales of Goods/Services		
CLIA User Fees	28	31
To The Public	1	
Intragovernmental	4	4
Interest & Penalties (Non-Fed)	1	3
Interest (Fed)	12,583	12,703
Other Revenue and Financing Sources *(Note 10)*	5,574	3,189
Trust Fund Draws	2,109	2,109
Revenue Transferred to Program Management	(2,109)	(2,109)
Less: Collections For Principal Repayments Transferred To The Federal Financing Bank	18	6
Total Revenues and Financing Sources	**260,475**	**249,870**
EXPENSES		
Program or Operating Expenses		
Medicare Benefit Payments *(Note 11)*	171,751	170,543
Medicaid Benefit Payments *(Note 11)*	88,002	86,670
Administrative Expenses *(Notes 11 and 12)*	2,830	2,760
Other *(Note 11)*	38	40
Depreciation and Amortization *(Note 11)*	5	6
Bad Debts and Writeoffs *(Note 11)*	1,734	
Other Expenses *(Notes 11 and 13)*	141	(354)
Total Expenses	**264,501**	**259,665**
Excess (Shortage) of Revenues/Financing Sources Over Total Expenses	**$(4,026)**	**$(9,795)**
Net Position, Beginning Balance	152,900	157,379
Plus (Minus) Prior Period Adjustment *(Note 14)*	3,682	(168)
Net Position, Beginning Balance as Restated	156,582	157,211
Excess (Shortage) of Revenues/Financing Sources Over Total Expenses	(4,026)	(9,795)
Plus (Minus) Non-Operating Changes *(Note 15)*	(1,499)	9,166
Net Position, Ending Balance	**$151,057**	**$156,582**

The accompanying notes are an integral part of these statements.

NOTES TO THE FINANCIAL STATEMENTS

Note 1: Summary of Significant Accounting Policies

Reporting Entity

The Health Care Financing Administration (HCFA) is considered a separate reporting entity of the Department of Health and Human Services (DHHS) for financial reporting purposes. The financial statements, required by the Chief Financial Officers Act of 1990, are prepared from HCFA's accounting records in accordance with the form and content specified by the Office of Management and Budget (OMB) in OMB Bulletin 94-01 and by DHHS's and HCFA's accounting policies, which are summarized in these footnotes.

The financial statements include the accounts of all funds administered by HCFA which are discussed below.

Medicare Hospital Insurance (HI)

Medicare contractors are paid by HCFA as our agents to receive and process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Payments made by the Medicare contractors for these services are withdrawn from the HI Trust Fund. This portion of the statements includes HI Trust Fund activities administered by the U.S. Department of Treasury.

Medicare Supplementary Medical Insurance (SMI)

Medicare contractors are also paid by HCFA to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, chronic renal disease, rural health clinic, and certain skilled nursing and home health services. Payments made by the Medicare contractors for these services are withdrawn from the SMI Trust Fund. This portion of the statements includes SMI Trust Fund activities administered by the U.S. Department of Treasury.

Medicaid

Medicaid, the health care program for low-income Americans, is administered in partnership by the States and the Federal government. Grant awards prepared by HCFA's Medicaid Bureau limit the advances that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of the Federal government's share of States' Medicaid costs. At the end of each quarter, States submit a report of their expenses, net of recoveries, for the quarter and subsequent grant awards are issued for the difference between approved expenses reported for the period and the grant awards previously issued.

These financial statements include the approved expenses reported by States for the first two quarters of FY 1995 and an estimate for the third and fourth quarter expenses. The estimate is an accrued amount based on the cash advanced to States in the third and fourth quarters to cover their expenses, which will be submitted for approval after September 30, 1995.

Program Management

The Program Management appropriation provides HCFA with the capacity to administer and oversee the Medicare and Medicaid programs. The funds for this activity are provided primarily by transfers from the HI and SMI Trust Funds. In addition, user fees collected from Health Maintenance Organizations seeking Federal qualification and reimbursement from other agencies for services performed for them by HCFA are credited to this appropriation. During FY 1995, the payments to the Health Care Trust Funds appropriation paid the Medicare HI Trust Fund

$129,758,000 to cover the Medicaid program's share of HCFA administrative costs. HCFA's cost allocation system determines the distribution of funds between the funding sources. All expenses chargeable to the Program Management appropriation, except HMO user fees and reimbursements from other agencies, are allocated to the Medicare HI and SMI and the Medicaid programs, and are reported to those programs in the Supplemental Information section of this report.

Funds are obtained from the HI and SMI Trust Funds as cash is needed to pay for Program Management appropriation expenses. During FY 1995, a total of $2,108,714,961 was obtained from the trust funds to cover cash outlays. Of this amount, $1,848,625,769 was needed to pay for expenses incurred against current year obligations and $260,089,192 was needed for expenses incurred against prior year obligations.

The following accounts are reported in the "All Others" column of these financial statements by activity.

SECA Credits

The Self-Employment Contribution Act provides for tax credits from the general funds of the Treasury. These credits represent the difference between the statutory SECA and the actual tax rate paid by the self-employed. The amounts reported in FY 1995 are adjustments to tax years 1984 through 1989. For purposes of financial statement presentation, the revenues and expenses for this account are reported only in the Medicare HI accounts.

Payments to the Health Care Trust Funds

The Social Security Act provides for payments to the Health Care Trust Funds for Supplementary Medical Insurance (appropriated funds to provide for Federal matching of SMI premium collections), Hospital Insurance for the Uninsured, and Federal Uninsured Payments. In addition, appropriated funds are provided to cover the Medicaid program's share of HCFA administrative costs. For purposes of financial statement presentation, the revenues and expenses of this appropriation are reported only in the Medicare HI and SMI accounts.

Suspense

Agencies are required to deposit receipts expeditiously. Unidentified collections are deposited into a suspense account for immediate availability to Treasury while HCFA researches the actual application of funds.

Miscellaneous Fines, Penalties, and Forfeitures

Civil monetary penalties and Freedom of Information administrative fees are assessed on overdue payments.

Interest Receipts

Interest resulting from debt collection is deposited to Treasury miscellaneous receipt accounts.

General Fund Receipts

The Freedom of Information Act provides for the proceeds from the sale of publications to be deposited to Treasury miscellaneous receipt accounts along with other miscellaneous recoveries and refunds.

Health Maintenance Organization (HMO) Loan Program

The Public Health Service's HMO program was transferred to HCFA in 1985. Included in this transfer was the HMO Loan and Loan Guarantee Fund, originally established to provide working capital to HMOs during their initial periods of operations and to guarantee loans made by private lenders to HMOs.

The last loan commitments were made in FY 1983. Direct loans to HMOs were sold, with a guarantee, to the Federal Financing Bank (FFB). The FFB purchase proceeds were then used as capital for additional direct loans. Therefore, the fund operates as a revolving fund. Currently, HCFA collects principal and interest payments from HMO borrowers and, in turn, pays the FFB.

Clinical Laboratory Improvement Amendments (CLIA)

The Clinical Laboratory Improvement Amendments of 1988 marked the first comprehensive Federal effort to regulate medical laboratory testing. HCFA and the Public Health Service share responsibility for the CLIA program, with HCFA having the lead responsibility for financial management.

Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Therefore, like the HMO program, the CLIA fund operates as a revolving fund.

Program Management

Activities related to HMO user fees and reimbursements from other agencies are reported here. The balance of the Program Management appropriation data is cost allocated among the HI and SMI Trust Funds and Medicaid and is presented in the Supplemental Information section of the Financial Report.

Income Tax on Old Age and Survivors and Disability Insurance (OASDI)

The Omnibus Budget Reconciliation Act of 1993 increased the maximum percentage of OASDI benefits that are subject to Federal income taxation under certain circumstances from 50 percent to 85 percent for taxable years beginning in 1994. The revenues resulting from this increase are transferred to the HI Trust Fund.

For purposes of financial statement presentation, the revenues and expenses for this account are reported only in the Medicare HI accounts.

Basis of Accounting

Transactions are recorded on both accrual and cash methods. Under the accrual method, expenses are recognized when a liability is incurred without regard to the payment of cash. Under the cash method, expenses are recognized when cash is outlayed.

The Medicare Program uses the cash method to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate the value of benefit payments incurred but not yet paid as of the fiscal-year end. Revenues are recognized when earned without regard to receipt of cash.

The cash method is used in the Medicaid Program to record draws by the States to cover current quarter expenses, supplemented by the accrual method to estimate the value of expenses, net of recoveries, not yet reported to HCFA as of the fiscal-year end. Revenues are recognized as appropriated capital is used.

Budgetary accounting facilitates compliance with legal constraints and controls over the use of Federal funds. HCFA uses the Government's Standard General Ledger account structure.

Funds with the U.S. Treasury and Cash

HCFA does not maintain cash in commercial bank accounts. Cash receipts and disbursements are processed by the U.S. Treasury. Funds with Treasury are primarily available to pay current liabilities. Cash balances held by Treasury are reconciled each month to control records maintained by HCFA.

Investments

Sections 1817(c) for HI and 1841(c) for SMI of the Social Security Act require that trust fund holdings not necessary to meet current expenditures be invested in "interest bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." These investments are carried at amortized cost as determined by the U.S. Treasury. Interest income is compounded semi-annually (June and December) and has been adjusted to include an accrual for interest earned from July 1 to September 30.

Retirement Plan

HCFA employees participate in the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Under CSRS, HCFA makes matching contributions equal to seven percent of pay. HCFA does not report CSRS assets, accumulated plan benefits, or unfunded liabilities, if any, applicable to its employees. Reporting such amounts is the responsibility of the Office of Personnel Management.

Most employees hired after December 31, 1983 are automatically covered by FERS. A primary feature of FERS is that it offers a savings plan to which HCFA is required to contribute one percent of pay, and to match employee contributions up to an additional four percent of pay. For employees covered by FERS, HCFA also contributes the employer's matching share of Social Security taxes.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 1995, HCFA has canceled over $67 million in obligations to FYs 1990 and prior in accordance with Public Law 101-510. Based on the payments made in FYs 1991 through 1995 related to canceled appropriations, HCFA anticipates an additional $5.3 million will be paid from current year funds for canceled obligations.

Accounting Changes

DHHS issued modifications for the treatment of accounts receivable based on OMB instructions and Standard General Ledger procedures. Essentially, these changes require agencies to restore obligational authority when collections occur, not when the receivable is established. The DHHS modifications also enable agencies to identify and record receivables deemed to be uncollectible as bad debt expenses (bad debt expense is now affected as the allowance for uncollectible accounts is affected). Prior to FY 1995, HCFA reported bad debt expense as a component of program expense. Since this accounting change involves an estimate, the accompanying FY 1994 Statement of Operations and Changes in Net Position has not been restated.

Limitations to the Financial Statements

These financial statements have been prepared to report the financial position and results of operations of HCFA as required by the Chief Financial Officers Act of 1990.

In accordance with guidance from the Office of Management and Budget, these financial statements have been prepared from HCFA's general ledger and subsidiary reports and supplemented with financial data prepared by the U.S. Treasury. These statements use accrual accounting, and some amounts shown will differ from those in other financial documents, such as the Budget of the U.S. Government and the annual reports of the Boards of Trustees for HI and SMI, which are represented on a cash basis.

These statements should be read with the realization that they are prepared by an independent entity of the Federal government, that liabilities not covered by budgetary resources cannot be liquidated without the enactment of an appropriation, and that the payment of all liabilities other than for contracts can be nullified by the entity.

Note 2: Fund Balances (Dollars in Millions)

Entity Fund Balances:	Obligated	Unobligated		Total
		Available	Restricted	
Trust Funds.....				
HI Trust Fund Balance	$(349)			$(349)
SMI Trust Fund Balance	351			351
Revolving Funds.....				
HMO Loan *(1)*	1	$10		11
CLIA *(1)*	7	15		22
Appropriated Funds.....				
Medicaid	4,606	12,740		17,346
Payments to the Health Care Trust Funds *(1)*			$7,988	7,988
Other Fund Types.....				
HCFA Suspense Account *(1)*		1		1
Total Entity Fund Balances	**$4,616**	**$12,766**	**$7,988**	**$25,370**

(1) These fund balances are reported in the Supplemental Information Section under "All Others" on the Statement of Financial Position by Activity.

Non-Entity Fund Balance

In FY 1994 the U.S. Treasury reported trust fund balances of $1 million in SMI and $916 million in HI. These balances properly represented receipts applicable to FY 1994, but were reported to Treasury at month-end September 1994. Treasury invests trust fund receipts daily in U.S. Treasury Special Issues, typically leaving fund balances within a $10-15 thousand range. Due to timing differences, however, these funds were invested in October 1994; trust fund balances were within the normal range as of September 30, 1995.

Note 3: Governmental Accounts Receivable (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Entity/Governmental						
Accounts Receivable	$3,089	$1,519	$4,608	$93	$10	$4,711
Less Allowance for Uncollectible Accounts	1,031	707	1,738			1,738
Net Entity Governmental A/R	**2,058**	**812**	**2,870**	**93**	**10**	**2,973**
Non-Entity/Governmental						
Accounts Receivable	109	325	434		375	809
Less Allowance for Uncollectible Accounts	13	53	66		252	318
Net Non-Entity Governmental A/R	**96**	**272**	**368**		**123**	**491**
Total Governmental A/R	**3,198**	**1,844**	**5,042**	**93**	**385**	**5,520**
Less Total Allowance for Uncollectible Accounts	**1,044**	**760**	**1,804**		**252**	**2,056**
Net Total Governmental A/R	**$2,154**	**$1,084**	**$3,238**	**$93**	**$133**	**$3,464**

The accounts receivable were primarily reported from data provided by the Medicare contractors. The majority of these receivables are due to overpayments to providers, beneficiaries, physicians and suppliers, and to those claims where Medicare should be the secondary rather than the primary payer (Medicare Secondary Payer claims). Only those MSP claims that have been identified to a debtor, and for which a collectible amount has been determined, are included in the accounts receivable. An additional 1.2 million claims are being researched as potential MSP accounts receivable and have not been reported due to the uncertain nature of the leads.

The MSP portion of the receivable may be overstated pending a final decision in the court case, HIAA/BCA V. SHALALA. The United States Circuit Court of Appeals for the District of Columbia invalidated a HCFA regulation that required group health plans to repay Medicare for certain mistaken payments, without regard to the plan's timely filing requirements. The case is now before the District Court for the District of Columbia awaiting a final decision. HCFA is issuing refunds in limited circumstances where collections have been received from plaintiffs in the case. The District Court may order HCFA to make refunds in additional circumstances and to other entities. Because a final ruling in this matter has not been made, and because it is possible that legislation might expand or limit the extent to which HCFA could make these repayments, a reasonable estimate for the potential overstatement of the receivable cannot be made.

The majority of the allowance for uncollectible accounts came from Medicare contractor data based on the last five years (if available) of historical loss experience by type. The allowance was adjusted for those contractors that did not report historical loss experience. The balance of the allowance was reported by HCFA components as a result of an analysis of individual debtors and group analyses that included accounts receivable that were outstanding for more than one year and did not have payment activity within that year. No allowance for doubtful accounts is shown for the Medicaid accounts receivable. The Medicaid accounts receivable has been recorded at a net realizable value, based on an historic analysis of actual recoveries and the rate of disallowances found in the favor of the States. Such disallowances are not considered bad debts; the States elect to retain the funds until final resolution.

The accounts receivable does not include established or contingent amounts due to States for overpayment of Medicaid funds to providers or for anticipated rebates from drug manufacturers, settlements from probate and fraud and abuse cases, or payments from insurance companies deemed to be primary payers. HCFA is not responsible for collecting amounts owed to States under the Medicaid program. Accordingly, the States report actual expenses, net of collections for the situations listed above, to HCFA for reimbursement.

The Office of Inspector General, however, believes that the accounts receivable balance could be materially understated if the State receivables are not reflected on HCFA's records. Therefore, through its participation in the Government-wide Financial Statements Audit Task Force, HCFA is reviewing several possibilities to determine the materiality of these receivables and to assess their impact on HCFA's financial statements. The issue also affects accounting and financial reporting for all DHHS public assistance programs and government-wide grant programs.

Note 4: Investments and Interest Receivable (Dollars in Millions)

	MATURITY RANGE	INTEREST RANGE	VALUE
HI			
Certificates	June 1996	6 1/2 - 6 5/8%	$262
Bonds	June 1996 to June 2010	6 1/4 - 13 3/4%	129,602
TOTAL HI INVESTMENTS			**129,864**
SMI			
Certificates	June 1996	6 1/2 - 6 5/8%	
Bonds	June 1996 to June 2009	6 1/4 - 13 3/4%	13,514
TOTAL SMI INVESTMENTS			**13,514**
TOTAL MEDICARE TRUST FUND INVESTMENTS			**$143,378**

U.S. Treasury Special Issues are special public obligations for exclusive purchase by the Medicare trust funds. Special issues are always purchased and redeemed at face value. The face value less amounts retired to fund Medicare program expenses by the programs is the net amount outstanding reported in the Combined Statement of Financial Position. This schedule summarizes the nature and amount of investments in the Medicare trust funds. See Statement of Accounts for HI and SMI Trust Fund Investments in the Supplemental Information section for a detailed description of the holdings.

Interest Receivable

The interest receivable is reported to HCFA by the U.S. Treasury and reflects the interest due the trust funds as of September 30, 1995 from the investments listed above.

Note 5: Accounts Payable (Dollars in Millions)

INTRAGOVERNMENTAL

Intragovernmental liabilities include:

* $16 due the U.S. Treasury for the uncollected portion of Trust Fund Miscellaneous Receipts; and

* $2 accrual of HCFA postal and rental expenses due the U.S. Post Office and General Services Administration, respectively.

GOVERNMENTAL

The $23,580 reported as accounts payable includes a $21,981 estimate by HCFA's Office of the Actuary of Medicare services for which payment has not yet been drawn from the HI or SMI Trust Funds as of September 30, 1995. The estimates are based on historical trends of completeness that take into consideration estimated deductible and coinsurance amounts. Additionally, the estimates consider known items such as (1) claims that have been submitted to the Medicare contractors who have yet to approve their payment, (2) claims that have been approved by the Medicare contractors who have yet to make payment, and (3) checks that have been issued by the Medicare contractors in payment of a claim but that have not yet been presented for reimbursement. A fourth element, which is unknown: the costs of services rendered as of September 30 but not yet billed, must be developed solely from actuarial techniques. The payable estimate is a by-product of the actuarial estimates that are included in the HI and SMI Annual Reports of the Boards of Trustees (whose methodology is also employed in all annual budget exercises, including the President's Budget and Mid-Session Review and in the annual development of the SMI premium). Moreover, the actuarial estimated accounts payable is a volatile amount due to the health care environment, and slight differences in the accumulated incurred benefits and accumulated cash benefits can cause substantial changes in the estimated amount.

Additionally, the accounts payable includes:

* $1,543 due to States under the Medicaid program based on amounts reported on the first and second quarter expenditure reports that exceed the first and second quarter advances drawn by the States, which is systematically adjusted in the following fiscal year;

* $52 accrual of HCFA Demonstrations Projects and HMO Benefit Payments; and

* $4 accrual for Program Management rent, utility, and miscellaneous charges.

The accounts payable does not include all provider cost reports under appeal at the Office of Hearings (OH). The monetary effect of these appeals is generally not known until a decision is rendered.

As of September 30, 1995, there were 9,101 cases in appeal at the OH. Approximately 2,400 of these cases were filed in FY 1995. The OH rendered decisions on 70 cases in FY 1995 while 1,914 additional cases were dismissed, withdrawn, or settled prior to an appeal hearing. The Office receives no information on the value of these cases that are settled prior to a hearing. In addition, a reasonable liability estimate cannot be projected for the value of the 9,101 cases remaining in appeal as of September 30 from the data available for the 70 cases that were decided in FY 1995. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

In its standard, Accounting for Liabilities of the Federal Government, the Federal Accounting Standards Advisory Board suggests the amounts due and payable by the States as of September 30 should be recorded as a liability on the financial statements of the Federal agencies administering the grant programs. The Office of Inspector General believes that HCFA's accounts payable is materially understated by not recording on HCFA's records the States' estimates for claims/services incurred but not reported (IBNR) to the States.

Currently, HCFA records a liability (as discussed above) and estimated expenses through September 30 based on the advances drawn by the States for the third and fourth quarters for reimbursement of the Federal share of the States' actual expenses. Through our participation in the Single Audit Subgroup of the Government-wide Task Force for Audited

Financial Statements, HCFA is pursuing a method to gather and validate Medicaid program liability data without burdening the States with additional reporting.

Note 6: Other Liabilities (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Liabilities Covered by Budgetary Resources						
Governmental:						
Premiums Billed/Not Yet Due and Unearned Advances	$92	$259	$351			**$351**
Liabilities Not Covered by Budgetary Resources						
Intragovernmental:						
Uncollected Revenue due Treasury					$123	**123**
Governmental:						
Medicaid Audit Disallowances Under Appeal				$5		5
Medicaid Program Disallowances Under Appeal				52		52
Medicaid Program Deferrals				260		260
Total Governmental Liabilities Not Covered by Budgetary Resources				$317		**$317**

Governmental liabilities covered by budgetary resources ($351) consist of (1) Medicare premiums billed (included in the FY 1995 accounts receivable reported) prior to September 30, 1995 but due in the following reporting period and (2) premiums that were received but unbilled.

Intragovernmental liabilities not covered by budgetary resources ($123) include uncollected revenue (interest, fees, penalties) due Treasury.

In addition, Governmental liabilities not covered by budgetary resources ($317) include contingent payables that have been established as a result of Medicaid audit and program disallowances that are currently being appealed by States. In all cases, the funds have been returned to HCFA. Accordingly, HCFA will be required to pay these amounts if the appeals are decided in favor of the States. Also, certain amounts for payment have been

deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. HCFA defers the payment of these claims until the State provides additional supporting data. Based on historical data, HCFA expects to eventually pay about 34.8 percent of total contingent payables. Therefore, of the total contingent payables of $908, HCFA expects to pay approximately $317.

Note 7: Net Position (Dollars in Millions)

BY PROGRAM	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Unexpended Appropriations:						
Unobligated						
Available	$115,300	$11,124	$126,424	$12,740	$26	$139,190
Unavailable					7,988	7,988
Undelivered Orders	380	302	682	3,474	11	4,167
Invested Capital	19	32	51	4		55
Less: Future Funding Requirements	8	17	25	318		343 *(1)*
Total	**$115,691**	**$11,441**	**$127,132**	**$15,900**	**$8,025**	**$151,057**

BY FUND TYPE	Revolving Funds	Trust Funds	Approriated Funds	Combined Total
Unexpended Appropriations:				
Unobligated				
Available	$26	$126,424	$12,740	$139,190
Unavailable			7,988	7,988
Undelivered Orders	11	682	3,474	4,167
Invested Capital		51	4	55
Less: Future Funding Requirements		25	318	343 *(1)*
Total	**$37**	**$127,132**	**$23,888**	**$151,057**

(1) Future funding will be required to pay the current year accrual for annual leave that has been allocated to the Medicare trust funds and Medicaid, for the current year liabilities (audit/program disallowances and deferrals) of the Medicaid program, and for current year Federal Employees' Compensation Benefit expenses.

Note 8: Employment Tax Revenue (Dollars in Millions)

In calendar year 1995, all employees and employers were each required to contribute 1.45 percent of employees' wages, with no limitation, to the Federal Medicare Hospital Insurance (HI) Trust Fund.

The Social Security Act requires the transfer of these contributions from the General Fund of the U.S. Treasury to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from the Social Security Administration's (SSA) records of wages established and maintained by SSA in accordance with wage information reports.

Pursuant to the Comptroller General (CG) of the United States Decision, B-261522, September 29, 1995, SSA, in certifying wages to the Secretary of the Treasury, may consider both individual employee wages as reported annually by employers to SSA (Form W-3) and the higher wage informat on reported quarterly by employers to the IRS on Forms 941. Prior to the CG decision, SSA had used the higher wage basis (Forms 941) for the wage certification; HCFA, pending settlement of the issue, recognized an Employment Tax Liability in FY 1994 for the difference between the two wage certification methods. As a result of the CG decision, HCFA has reversed the Employment Tax Liability (see Note 14: Prior Period Adjustments), and has restated the FY 1994 Net Position on the Statement of Financial Position.

Note 9: SMI Premiums Collected and Federal Matching Contributions

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and matched daily by the Federal government. The Omnibus Budget Reconciliation Act of 1990 (OBRA) set specific monthly premium levels for five calendar years beginning in 1991. The monthly premium as established by OBRA was $46.10 for calendar year 1995 and covered approximately 30 percent of the FY 1995 SMI program expenses. Premiums collected from beneficiaries totaled $19.2 billion in FY 1995 and were matched by a $37 billion contribution from the Federal government. This represents a Federal match of approximately $1.92 to every $1 collected in premiums.

Note 10: Other Revenue and Financing Sources (Dollars in Millions)

	Medicare		Total	All	Combined
	HI	SMI	Medicare	Others	Total
Premiums-Uninsured Individuals	$999		$999		$999
Transfer-Uninsured Coverage	592		592		592
Military Service Contribution	61		61		61
Principal Payments				$6	6
Income Tax Credit Reimbursement	(1)		(1)		(1)
Income Tax OASDI Benefits *(1)*	3,913		3,913		3,913
Gifts and Miscellaneous	1	$3	4		4
Total Other Revenue	**$5,565**	**$3**	**$5,568**	**$6**	**$5,574**

(1) In FY 1994, HCFA established an account on its general ledger to record transfers of OASDI revenues to the HI Trust Fund. For that year, HCFA reported transfers of $1.639 billion for the final two quarters of the fiscal year (the account took effect in April 1994). The FY 1995 reported transfers, totaling $3.913 billion, represent an entire fiscal year's worth of transfers.

Note 11: Expenses by Object Class (Dollars in Millions)

	Medicare		Total		All	Combined
	HI	SMI	Medicare	Medicaid	Others	Total
Program Expenses by Object Class:						
Medicare						
Insurance Claims and Indemnities	$109,553	$62,198	$171,751			$171,751
Medicaid						
Grants, Subsidies and Contributions				$88,002		88,002
Other Expenses *(See Note 13)*	1	2	3	138		141
Total Program Expenses	**109,554**	**62,200**	**171,754**	**88,140**		**259,894**
Operating Expenses by Object Class:						
Administrative						
Personal Services and Benefits	92	183	275	14	$5	294
Contractual Services	846	1,558	2,404	99	33	2,536
Total Operating Expenses	**938**	**1,741**	**2,679**	**113**	**38**	**2,830**
Other						
Travel and Transportation	2	5	7			7
Rental, Communication and Utilities	4	10	14	1		15
Printing and Reproduction	3	8	11	2		13
Supplies and Materials	1	2	3			3
Total Other Expenses	**10**	**25**	**35**	**3**		**38**
Depreciation and Amortization	1	4	5			**5**
Bad Debts and Writeoffs	1,031	703	1,734			**1,734**
Total Expenses by Object Class	**$111,534**	**$64,673**	**$176,207**	**$88,256**	**$38**	**$264,501**

Note 12: Administrative Expenses (Dollars in Millions)

MEDICARE

Hospital Insurance

U.S. Department of Treasury	$45
Social Security Administration (SSA)	476
Health Care Financing Administration	589
Office of the Secretary - DHHS	9
Payment Assessment Commission	4
Policy and Research	3
Railroad Retirement Board	(358)
Peer Review Organizations	180
TOTAL HI ADMINISTRATIVE EXPENSE	**948**

Supplementary Medical Insurance

U.S. Dept. of Treasury/Office of Personnel Mgmt.	1
Social Security Administration	356
Health Care Financing Administration	1,380
Office of the Secretary - DHHS	7
Payment Assessment Com./SSA Construction	1
Policy and Research	2
Physicians Payment Review Commission	4
Railroad Retirement Board	5
Peer Review Organizations	10
TOTAL SMI ADMINISTRATIVE EXPENSE	**1,766**
TOTAL MEDICARE TRUST FUND ADMINISTRATIVE EXPENSE	**2,714**
MEDICAID	
Health Care Financing Administration	116
TOTAL ADMINISTRATIVE EXPENSES	**$2,830**

Note 13: Other Expenses (Dollars in Millions)

	Medicare		Total		All	Combined
	HI	SMI	Medicare	Medicaid	Others	Total
FY 1995 Unfunded Annual and Compensatory Leave and Unfunded FECA Expense	$1	$2	$3			$3
FY 1995 Contingent Liabilities						
Program Deferrals				$105		105
Program Disallowances Under Appeal				35		35
Audit Disallowances Under Appeal				(2)		(2)
Total Other Expenses	**$1**	**$2**	**$3**	**$138**		**$141**

HCFA accrues an unfunded Annual and Compensatory leave expense and an unfunded Federal Employees' Compensation Benefits (FECA) expense which are allocated to the Medicare trust funds. FECA expenses are determined by the Department of Labor.

Medicaid audit and program disallowances under appeal and Medicaid deferrals are classified as liabilities not covered by budgetary resources on the Statement of Financial Position. As discussed in Note 6, Other Governmental Liabilities, these contingent amounts will be paid if the appeals are decided in favor of the claimant and if additional data is provided to support the legitimacy of a Medicaid expenditure claim. A negative expense occurs when more liabilities established in prior fiscal years are settled during FY 1995 than were recognized in the current year.

Note 14: Prior Period Adjustments (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Employment Tax Liability for FY 1994 and prior *(1)*	$3,682		$3,682			$3,682
TOTAL PRIOR PERIOD ADJUSTMENTS	**$3,682**		**$3,682**			**$3,682**

(1) Pursuant to the Comptroller General of the United States Decision, B-261522, September 29, 1995, the Employment Tax Liability of the HI Trust Fund established in FY 1994 has been reversed. (See Note 8.)

Note 15: Non-Operating Changes (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Payments to the Health Care Trust Funds *(1)*					$(33)	$(33)
Cancelled Year Funds	$(1)	$(1)	$(2)		(2,715)	(2,717)
Current Year Warrants Exceeding Appropriated Capital Used				$1,239	12	1,251
TOTAL NON-OPERATING CHANGES	**$(1)**	**$(1)**	**$(2)**	**$1,239**	**$(2,736)**	**$(1,499)**

(1) Due to timing differences, a portion of the September 1994 payments to the Health Care Trust Funds was processed and reported by HCFA in FY 1995. Although HCFA reported these payments against the FY 1994 appropriation, Treasury did not have constructive receipt of these payments for its investment purposes until FY 1995. Thus, the draw from the FY 1994 appropriation has been reported as a non-operating change in FY 1995.

SUPPLEMENTAL INFORMATION

COMBINED STATEMENT OF FINANCIAL POSITION BY ACTIVITY
AS OF SEPTEMBER 30, 1995

(Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
ASSETS						
Entity Assets:						
Intragovernmental Assets:						
Fund Balances	$(349)	$351	$2	$17,346	$8,022	$25,370
Accounts Receivable, Net	1	2	3			3
Governmental Assets:						
Accounts Receivable, Net	2,058	812	2,870	93	10	2,973
Advances and Prepayments	9	4	13	320	4	337
Property and Equipment, Net	19	33	52	3		55
Total Entity Assets	**1,738**	**1,202**	**2,940**	**17,762**	**8,036**	**28,738**
Non-Entity Assets:						
Intragovernmental Assets:						
Interest Receivable	2,624	261	2,885			2,885
Investments	129,864	13,514	143,378			143,378
Governmental Assets:						
Accounts Receivable, Net	96	272	368		123	491
Total Non-Entity Assets	**132,584**	**14,047**	**146,631**		**123**	**146,754**
TOTAL ASSETS	**134,322**	**15,249**	**149,571**	**17,762**	**8,159**	**175,492**
LIABILITIES						
Liabilities Covered by Budgetary Resources:						
Intragovernmental Liabilities:						
Accounts Payable	4	14	18			18
Liabilities for Loan Guarantees					9	9
Governmental Liabilities:						
Accounts Payable	18,524	3,512	22,036	1,543	1	23,580
Suspense Accounts Deposit Funds					1	1
Accrued Payroll and Benefits	3	6	9	1		10
Other Governmental Liabilities	92	259	351			351
Total Liabilities Covered by Budgetary Resources	**18,623**	**3,791**	**22,414**	**1,544**	**11**	**23,969**
Liabilities not Covered by Budgetary Resources:						
Intragovernmental Liabilities:						
Accounts Payable	2	4	6			6
Uncollected Revenue due Treasury					123	123
Governmental Liabilities:						
Accrued Leave	6	13	19	1		20
Other Governmental Liabilities				317		317
Total Liabilities not Covered by Budgetary Resources	**8**	**17**	**25**	**318**	**123**	**466**
TOTAL LIABILITIES	**18,631**	**3,808**	**22,439**	**1,862**	**134**	**24,435**
NET POSITION						
Balances:						
Unexpended Appropriations	115,680	11,426	127,106	16,214	8,025	151,345
Invested Capital	19	32	51	4		55
Less: Future Funding Requirements	8	17	25	318		343
TOTAL NET POSITION	**115,691**	**11,441**	**127,132**	**15,900**	**8,025**	**151,057**
TOTAL LIABILITIES & NET POSITION	**$134,322**	**$15,249**	**$149,571**	**$17,762**	**$8,159**	**$175,492**

COMBINED STATEMENT OF OPERATIONS AND CHANGES IN NET POSITION BY ACTIVITY
FOR THE PERIOD ENDING SEPTEMBER 30, 1995

(Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
REVENUE AND FINANCING SOURCES						
Direct Appropriations Expended				$88,002	$15	$88,017
Employment Tax Revenue	$98,054		$98,054			98,054
SMI Premiums Collected		$19,243	19,243			19,243
Federal Matching Contributions		36,988	36,988			36,988
Revenue From Sales of Goods/Services						
CLIA User Fees					28	28
To The Public					1	1
Intragovernmental					4	4
Interest & Penalties (Non-Fed)					1	1
Interest (Fed)	10,838	1,745	12,583			12,583
Other Revenue and Financing Sources	5,565	3	5,568		6	5,574
Trust Fund Draws	596	1,395	1,991	118		2,109
Revenue Transferred to Program Management	(764)	(1,345)	(2,109)			(2,109)
Less: Collections for Principal Repayments Transferred To The Federal Financing Bank					18	18
Total Revenues and Financing Sources	**114,289**	**58,029**	**172,318**	**88,120**	**37**	**260,475**
EXPENSES						
Program or Operating Expenses						
Medicare Benefit Payments	109,553	62,198	171,751			171,751
Medicaid Benefit Payments				88,002		88,002
Administrative Expenses	948	1,766	2,714	116		2,830
Other					38	38
Depreciation and Amortization	1	4	5			5
Bad Debts and Writeoffs	1,031	703	1,734			1,734
Other Expenses	1	2	3	138		141
Total Expenses	**111,534**	**64,673**	**176,207**	**88,256**	**38**	**264,501**
Excess (Shortage) of Revenues/Financing Sources Over Total Expenses	**2,755**	**(6,644)**	**(3,889)**	**(136)**	**(1)**	**(4,026)**
Net Position, Beginning Balance	109,255	18,086	127,341	14,797	10,762	152,900
Plus (Minus) Prior Period Adjustments	3,682		3,682			3,682
Net Position, Beginning Balance as Restated	112,937	18,086	131,023	14,797	10,762	156,582
Excess (Shortage) of Revenues/Financing Sources Over Total Expenses	2,755	(6,644)	(3,889)	(136)	(1)	(4,026)
Plus (Minus) Non-Operating Changes	(1)	(1)	(2)	1,239	(2,736)	(1,499)
NET POSITION, ENDING BALANCE	**$115,691**	**$11,441**	**$127,132**	**$15,900**	**$8,025**	**$151,057**

HOSPITAL INSURANCE TRUST FUND PROJECTIONS

(Dollars in Billions)

Calendar Year	Total Income	Total Disbursements	Net Increase in Fund	Fund at End of Year	Ration: Assets to Disbursements
1994	109.6	104.5	5.0	132.8	122
1995	117.4	113.9	3.4	136.3	117
1996	124.1	125.0	(0.9)	135.4	109
1997	129.3	135.6	(6.2)	129.2	100
1998	134.6	146.5	(11.9)	117.3	88
1999	139.4	158.2	(18.8)	98.4	74
2000	144.5	170.8	(26.3)	72.1	58
2001	149.7	184.5	(34.7)	37.4	39
2002	154.9	199.0	(44.1)	*1/*	19

1/ Trust Fund Depleted in year 2002

Reflects intermediate actuarial assumptions of the 1995 Annual Report of the Trustees of the HI Trust Fund.

SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND PROJECTIONS

(Dollars in Billions)

Calendar Year	Enrollee Premiums	Other Income	Total Income	Total Disbursements	Fund at End of Year
1994	17.4	38.2	55.6	60.3	19.4
1995	19.7	47.2	66.9	69.0	17.4
1996	19.0	59.8	78.8	78.0	18.1
1997	21.1	66.1	87.3	86.4	19.0
1998	23.5	73.1	96.6	95.7	20.0
1999	24.5	82.5	107.1	106.0	21.0
2000	25.6	93.2	118.9	117.7	22.2
2001	26.8	105.3	132.2	130.8	23.6
2002	28.1	119.1	147.2	145.7	25.0
2003	29.5	135.1	164.6	162.9	26.8
2004	31.1	153.3	184.4	182.4	28.7

Reflects intermediate actuarial assumptions of the 1995 Annual Report of the Trustees of the SMI Trust Fund.

HCFA PROGRAM MANAGEMENT OUTLAYS

(Dollars in Millions)	FY 1993	FY 1994	FY 1995
Research	$69	$72	$73
Medicare Contractors	1,503	1,545	1,532
State Certification	136	165	139
HCFA Administrative Costs	335	330	367
Reimbursables	1		3
Total Outlays	$2,044	$2,112	$2,114

MEDICARE PAYMENT SAFEGUARDS

(Dollars in Milllions)	FY 1993	FY 1994	FY 1995
Investments (Outlays)	$406	$412	$414
Savings:			
Medicare Secondary Payer	3,135	2,963	3,446
Provider Audit	1,711	1,117	1,306
Medical & Utilization Review	1,412	1,231	1,841
Total Savings	$6,258	$5,311	$6,593

TOTAL OUTLAYS

(Dollars in Millions)	FY 1993	FY 1994	FY 1995
Medicare Benefits			
HI	$90,534	$101,350	$113,403
SMI	52,401	57,996	63,482
Total	142,935	159,346	176,885
Medicaid Grants to States			
Medical Assistance Payments	72,791	78,763	85,379
State & Local Administration	2,983	3,271	3,691
Total	75,774	82,034	89,070
Administration			
HCFA Program Management	2,044	2,112	2,114
Peer Review Review Organization	214	195	190
SSA and Other Federal Agencies	406	449	554
CLIA and HMO Loan	27	29	34
Total	2,691	2,785	2,892
Total Benefit and Administration Outlays	**$221,400**	**$244,165**	**$268,847**

TOTAL BENEFICIARIES

(Persons in Millions)	FY 1993	FY 1994	FY 1995
Medicare (Eligible to receive benefits)	36.1	37.0	37.5
Medicaid (Received benefits)	33.3	34.9	36.2
Total	69.4	71.9	73.7

RESEARCH AND DEMONSTRATIONS

The goal of HCFA's research, demonstration, and evaluation program is to provide timely, reliable information required for informed and rational decision-making in the Medicare and Medicaid programs.

This goal was pursued through four primary objectives:

1. Monitor and evaluate performance of HCFA programs in terms of access, quality, efficiency, and costs.

2. Further refine existing payment systems and to develop new payment, cost containment, and financing systems.

3. Develop new approaches to meet health care needs of vulnerable populations.

4. Develop information systems to improve consumer choice and health status.

HCFA made significant strides toward fulfilling its primary research objectives. Major accomplishments included:

- HCFA began development of a framework for a comprehensive monitoring and evaluation system for HCFA programs. This system will help identify areas of potential access problems and guide evaluation to identify barriers to care.

- In 1995, for the first time, socioeconomic data from the U.S. Census were linked to Medicare data. Analyses show that low income beneficiaries are at risk of higher mortality and of greater barriers to primary care.

- HCFA initiated a major multi-agency initiative, Operation Restore Trust, aimed at curbing fraud and abuse especially by nursing homes, home health agencies, and DME suppliers.

- HCFA continued evaluating the impact of the Medicare Physician Payment Reform on Access to Care. This study has produced findings to inform Congress and other policy makers that physician payment reform does not appear to have had a detrimental impact on access to care. It has also shown that there are vulnerable subgroups who continue to experience barriers to care.

- HCFA conducted data collection and analysis for generating procedure-specific practice expense estimates for all services under the Medicare Fee Schedule.

- HCFA continued the implementation of Phase II of the Home Health Prospective Payment Demonstration to test prospective payments per episode of care and began development and implementation of an outcome-based, patient-centered quality assurance system for Phase II.

- HCFA continued research to develop improved risk adjustment mechanisms for payment systems, both basic (e.g., carve outs and high cost cases) and more complex (e.g., ambulatory care groups, diagnostic cost groups, payment amounts for capitated systems, ACG and DCG hybrid adjustors, and other risk adjustors based on more clinical data and survey data).

- Past Office of Research and Demonstrations (ORD) research pioneered the concept of bundling payments, in which providers are paid a flat rate or package price for a group of services. HCFA continued to develop applications of the bundling concept to surgical episodes, including episode windows and consolidating payment across provider types.

- HCFA announced the Medicare Choices demonstration, a demonstration project aimed at expanding the types of managed care plans available to Medicare beneficiaries and at testing different payment methods.

- HCFA continued evaluations of numerous managed care arrangements, including the TEFRA HMO/CMP program, Medicare Select, a Medicare case management demonstration, and Medicare managed care programs with 1915(b) waivers. Results have been used by policy makers at all levels in both the public and private sectors.

- Six sites were awarded grant funding to support expansion of the Social HMO model of care. The second generation Social HMO focuses on refining the targeting and financing methodologies and benefit design of a Social HMO, with an emphasis on geriatric care and the extension of the model to special populations.

- Through the use of 1115 waivers, HCFA has expanded the use of managed care services to Medicaid beneficiaries in more than a dozen States. The result has been the provision of coverage to some 8 million persons, many of whom were previously uninsured.

- HCFA conducted projects to demonstrate and evaluate the development of payment systems for telemedicine services under Medicare.

- HCFA continued operation of the Rural Health Care Transition Grant Program and the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) Grant Program.

- Eleven awards were made to the Dissertation Fellowship Program, a new grant program designed to stimulate the involvement of new health service researchers in the study of health care financing and delivery issues.

- A contract was awarded to develop a final design for the survey, entitled the Medicare Beneficiary Health Status Registry, to monitor and evaluate the health status of Medicare beneficiaries throughout their enrollment in the program.

- Information has been developed on the level of flu immunization in 1993 among Medicare beneficiaries. These data were widely disseminated to inform consumers and providers about flu immunization levels and are being used nationally for health promotion and disease prevention.

- Information was published on mammography utilization rates among Medicare women. These data are being used nationally to promote this important preventive service.

ORD funded 177 extramural research projects, including 102 new projects and 75 continued from previous years under its regular research program. Obligations for this ongoing research program totaled $45 million. A total of $13.9 million was spent on Medicaid research, $31.1 million on Medicare research.

HCFA also issued 419 grants under three major grant programs totaling $29.5 million. Grant activity included the Rural Health Care Transition program, totaling $16.6 million in grants to 359 hospitals and $.9 million in contract funding evaluation activities; EACH/RPCH, totaling $2 million to seven States; and Insurance Counseling grants, totaling $10 million, awarded to the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT

Material Weaknesses

Medicare Secondary Payer (MSP) Over the last several years, HCFA has actively pursued several initiatives to improve the MSP program: legislative proposals, litigation against noncomplying insurers, and data matches with SSA and IRS. Even with these current initiatives, some estimates project that the Medicare program may unnecessarily pay out as much as $400 million annually because fiscal intermediaries and carriers do not always identify primary payers. However, due to improvements in the MSP program, savings for FY 1994 were $3 billion and it is estimated that savings will reach $3.4 billion for FY 1995. The return on investment is impressive: in FY 1994, for every dollar spent on administrative costs (including recovery), $35 was saved. Because of recent litigation, the return for FY 1995 will be $31.

Ongoing initiatives will focus on (1) preventing inappropriate primary payments by Medicare through continued implementation and "user friendly" customization of the beneficiary initial enrollment questionnaire (I.Q.), and (2) implementing data sharing agreements between HCFA and private insurers to prevent duplication of primary payments and to assist in recovery.

Funding Payment Safeguards Inadequate or fluctuating program funding for payment safeguards has prevented Medicare contractors from maintaining adequate, well-trained, and experienced staff to perform the payment safeguard functions consistent with program guidelines. To preclude these uncertainties, HCFA proposed the Medicare Beneficiary Integrity System (formerly Benefits Quality Assurance Program) which increases funding for payment safeguards through direct apportionment from the Medicare trust funds. In addition, HCFA has proposed Contract Reform Legislation to allow contracting with entities other than insurance companies to provide payment safeguards for Medicare trust funds.

Medicare Accounts Receivable HCFA and OIG staff continue to review the ability of contractor controls to comprehensively monitor accounts receivable data. Previously, HCFA awarded funds for a pilot project to develop a protocol for use by contractors to self-assess key internal controls. A draft protocol was subsequently developed and tested onsite by one contractor. The results of this field testing were reviewed at a conference, convened from June 27-29, 1995, attended by representatives of intermediaries, carriers, OIG, and HCFA. Thereafter, attendees agreed to identify major contractor functions and to form workgroups for the purpose of developing control objectives and protocol guidelines. Through telecommunications and electronic media, work on the control objectives and suggested protocol guidelines continues.

STATEMENT OF ACCOUNT FOR HI TRUST FUND INVESTMENTS
DESCRIPTION OF HOLDINGS AS OF SEPTEMBER 30, 1995

U. S. TREASURY SPECIAL ISSUES:

Certificates of Indebtedness:	**Amount Issued**	**Less Amount Retired**	**Net Amount Outstanding**
6-1/2% maturing June 30, 1996	$7,621,150,000.00	$7,621,150,000.00	$0.00
6-5/8% maturing June 30, 1996	7,652,412,000.00	7,652,412,000.00	0.00
6-1/2% maturing June 30, 1996	9,131,165,000.00	8,869,497,000.00	261,668,000.00
Total Certificates of Indebtedness	**$24,404,727,000.00**	**$24,143,059,000.00**	**$261,668,000.00**

Bonds:	**Amount Issued**	**Less Amount Retired**	**Net Amount Outstanding**
13-3/4% due June 30, 1999	$850,544,000.00	$0.00	$850,544,000.00
13-3/4% due June 30, 1998	262,134,000.00	0.00	262,134,000.00
13-1/4% due June 30, 1997	1,450,129,000.00	0.00	1,450,129,000.00
13-1/4% due June 30, 1996	272,853,000.00	0.00	272,853,000.00
13% due June 30, 1996	1,177,276,000.00	0.00	1,177,276,000.00
10-3/4% due June 30, 1998	588,410,000.00	0.00	588,410,000.00
10-3/8% due June 30, 2000	1,277,566,000.00	0.00	1,277,566,000.00
10-3/8% due June 30, 1999	427,022,000.00	0.00	427,022,000.00
10-3/8% due June 30, 1998	427,022,000.00	0.00	427,022,000.00
9-1/4% due June 30, 2003	4,229,944,000.00	0.00	4,229,944,000.00
9-1/4% due June 30, 2002	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 2001	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 2000	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 1999	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 1998	1,034,541,000.00	0.00	1,034,541,000.00
9-1/4% due June 30, 1997	1,034,541,000.00	0.00	1,034,541,000.00
9-1/4% due June 30, 1996	1,034,541,000.00	0.00	1,034,541,000.00
8-3/4% due June 30, 2005	6,415,695,000.00	0.00	6,415,695,000.00
8-3/4% due June 30, 2004	6,415,695,000.00	0.00	6,415,695,000.00
8-3/4% due June 30, 2003	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 2002	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 2001	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 2000	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 1999	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 1998	2,185,752,000.00	0.00	2,185,752,000.00
8-3/4% due June 30, 1997	2,185,752,000.00	0.00	2,185,752,000.00
8-3/4% due June 30, 1996	2,185,752,000.00	1,589,285,000.00	596,467,000.00
8-5/8% due June 30, 2002	3,195,402,000.00	0.00	3,195,402,000.00
8-5/8% due June 30, 2001	686,250,000.00	0.00	686,250,000.00
8-5/8% due June 30, 2000	686,250,000.00	0.00	686,250,000.00
8-5/8% due June 30, 1999	686,250,000.00	0.00	686,250,000.00
8-5/8% due June 30, 1998	686,251,000.00	0.00	686,251,000.00
8-5/8% due June 30, 1997	686,251,000.00	0.00	686,251,000.00
8-5/8% due June 30, 1996	686,250,000.00	686,250,000.00	0.00
8-3/8% due June 30, 2001	2,509,152,000.00	0.00	2,509,152,000.00
8-3/8% due June 30, 2000	1,231,586,000.00	0.00	1,231,586,000.00
8-3/8% due June 30, 1999	1,231,586,000.00	0.00	1,231,586,000.00
8-3/8% due June 30, 1998	1,231,586,000.00	0.00	1,231,586,000.00
8-3/8% due June 30, 1997	1,059,023,000.00	0.00	1,059,023,000.00
8-3/8% due June 30, 1996	1,059,024,000.00	1,059,024,000.00	0.00
8-1/8% due June 30, 2006	7,316,968,000.00	0.00	7,316,968,000.00
8-1/8% due June 30, 2005	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 2004	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 2003	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 2002	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 2001	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 2000	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 1999	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 1998	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 1997	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 1996	901,273,000.00	901,273,000.00	0.00

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
7-3/8% due June 30, 2007	8,184,929,000.00	0.00	8,184,929,000.00
7-3/8% due June 30, 2006	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2005	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2004	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2003	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2002	867,960,000.00	0.00	867,960,000.00
7-3/8% due June 30, 2001	867,960,000.00	0.00	867,960,000.00
7-3/8% due June 30, 2000	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1999	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1998	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1997	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1996	867,961,000.00	867,961,000.00	0.00
7-1/4% due June 30, 2009	8,773,256,000.00	0.00	8,773,256,000.00
7-1/4% due June 30, 2008	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 2007	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 2006	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2005	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2004	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2003	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2002	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2001	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2000	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 1999	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 1998	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 1997	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 1996	225,130,000.00	225,130,000.00	0.00
6-1/4% due June 30, 2008	8,548,126,000.00	0.00	8,548,126,000.00
6-1/4% due June 30, 2007	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 2006	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2005	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2004	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2003	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2002	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2001	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2000	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 1999	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 1998	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 1997	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 1996	363,197,000.00	363,197,000.00	0.00
6-1/2% due June 30, 2010	9,037,246,000.00	0.00	9,037,246,000.00
6-1/2% due June 30, 2009	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2008	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2007	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2006	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2005	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2004	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2003	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2002	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2001	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2000	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 1999	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 1998	263,989,000.00	0.00	263,989,000.00
6-1/2% due June 30, 1997	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 1996	263,990,000.00	263,990,000.00	0.00
Total Bonds	**$135,558,692,000.00**	**$5,956,110,000.00**	**$129,602,582,000.00**
Total U. S. Treasury Special Issues	**$159,963,419,000.00**	**$30,099,169,000.00**	**$129,864,250,000.00**

Source: **Department of the Treasury**
Financial Management Service
Funds Management Division
Funds Accounting Branch

STATEMENT OF ACCOUNT FOR SMI TRUST FUND INVESTMENTS
DESCRIPTION OF HOLDINGS AS OF SEPTEMBER 30, 1995

U.S. TREASURY SPECIAL ISSUES:

Certificates of Indebtedness:	**Amount Issued**	**Less Amount Retired**	**Net Amount Outstanding**
6-1/2% maturing June 30, 1996	$5,627,448,000.00	$5,627,448,000.00	$0.00
6-5/8% maturing June 30, 1996	2,950,013,000.00	2,950,013,000.00	0.00
6-1/2% maturing June 30, 1996	2,029,175,000.00	2,029,175,000.00	0.00
Total Certificates of Indebtedness	**$10,606,636,000.00**	**$10,606,636,000.00**	**$0.00**

Bonds:	**Amount Issued**	**Less Amount Retired**	**Net Amount Outstanding**
13-3/4% due June 30, 1999	$567,103,000.00	$567,103,000.00	$0.00
13-3/4% due June 30, 1998	110,114,000.00	110,114,000.00	0.00
13-3/4% due June 30, 1997	110,115,000.00	110,115,000.00	0.00
13-1/4% due June 30, 1997	368,928,000.00	368,928,000.00	0.00
10-3/4% due June 30, 1998	456,989,000.00	456,989,000.00	0.00
10-3/4% due June 30, 1997	88,061,000.00	88,061,000.00	0.00
10-3/8% due June 30, 2000	733,187,000.00	733,187,000.00	0.00
10-3/8% due June 30, 1999	166,084,000.00	166,084,000.00	0.00
10-3/8% due June 30, 1998	166,084,000.00	166,084,000.00	0.00
10-3/8% due June 30, 1997	166,083,000.00	166,083,000.00	0.00
8-3/4% due June 30, 2005	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2004	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2003	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2002	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2001	547,163,000.00	0.00	547,163,000.00
8-3/4% due June 30, 2000	258,246,000.00	258,246,000.00	0.00
8-3/4% due June 30, 1999	258,246,000.00	258,246,000.00	0.00
8-3/4% due June 30, 1998	258,247,000.00	258,247,000.00	0.00
8-3/4% due June 30, 1997	258,247,000.00	258,247,000.00	0.00
8-3/8% due June 30, 2001	444,270,000.00	41,787,000.00	402,483,000.00
8-1/8% due June 30, 2006	1,218,813,000.00	0.00	1,218,813,000.00
8-1/8% due June 30, 2005	227,380,000.00	0.00	227,380,000.00
8-1/8% due June 30, 2004	227,381,000.00	0.00	227,381,000.00
8-1/8% due June 30, 2003	227,381,000.00	0.00	227,381,000.00
8-1/8% due June 30, 2002	227,381,000.00	0.00	227,381,000.00
8-1/8% due June 30, 2001	227,381,000.00	227,381,000.00	0.00
8-1/8% due June 30, 2000	227,381,000.00	227,381,000.00	0.00
8-1/8% due June 30, 1999	227,381,000.00	227,381,000.00	0.00
8-1/8% due June 30, 1998	227,380,000.00	227,380,000.00	0.00
7-3/8% due June 30, 2007	1,293,107,000.00	0.00	1,293,107,000.00
7-3/8% due June 30, 2006	74,295,000.00	0.00	74,295,000.00
7-3/8% due June 30, 2005	74,295,000.00	0.00	74,295,000.00
7-3/8% due June 30, 2004	74,294,000.00	0.00	74,294,000.00

STATEMENT OF ACCOUNT FOR SMI TRUST FUND INVESTMENTS

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
7-3/8% due June 30, 2003	74,294,000.00	0.00	74,294,000.00
7-3/8% due June 30, 2002	74,294,000.00	0.00	74,294,000.00
7-3/8% due June 30, 2001	74,294,000.00	74,294,000.00	0.00
7-3/8% due June 30, 2000	74,294,000.00	74,294,000.00	0.00
7-3/8% due June 30, 1999	74,294,000.00	74,294,000.00	0.00
7-3/8% due June 30, 1998	74,294,000.00	74,294,000.00	0.00
7-1/4% due June 30, 2009	1,570,476,000.00	0.00	1,570,476,000.00
7-1/4% due June 30, 2008	47,113,000.00	0.00	47,113,000.00
7-1/4% due June 30, 2007	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2006	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2005	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2004	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2003	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2002	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2001	47,112,000.00	47,112,000.00	0.00
7-1/4% due June 30, 2000	47,112,000.00	47,112,000.00	0.00
7-1/4% due June 30, 1999	47,112,000.00	47,112,000.00	0.00
7-1/4% due June 30, 1998	47,112,000.00	47,112,000.00	0.00
6-1/4% due June 30, 2008	1,523,363,000.00	0.00	1,523,363,000.00
6-1/4% due June 30, 2007	230,257,000.00	0.00	230,257,000.00
6-1/4% due June 30, 2006	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2005	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2004	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2003	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2002	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2001	230,256,000.00	230,256,000.00	0.00
6-1/4% due June 30, 2000	230,256,000.00	230,256,000.00	0.00
6-1/4% due June 30, 1999	230,256,000.00	230,256,000.00	0.00
6-1/4% due June 30, 1998	230,256,000.00	230,256,000.00	0.00
6-1/2% due June 30, 1996	1,923,411,000.00	1,923,411,000.00	0.00
Total Bonds	**$21,760,557,000.00**	**$8,247,103,000.00**	**$13,513,454,000.00**
Total U. S. Treasury Special Issues	**$32,367,193,000.00**	**$18,853,739,000.00**	**$13,513,454,000.00**

Source: **Department of the Treasury**
Financial Management Service
Funds Management Division
Funds Accounting Branch

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

INDEPENDENT AUDITORS' REPORT

INSPECTOR GENERAL'S REPORT ON FINANCIAL STATEMENTS

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

OVERVIEW

In accordance with the Chief Financial Officers (CFO) Act of 1990, this report presents the results of our efforts to audit the Health Care Financing Administration's (HCFA) combined financial statements for Fiscal Year (FY) 1995 and an assessment of its internal controls and compliance with laws and regulations.

These statements represent the fourth year of HCFA's implementation of the financial statements reporting requirement of the CFO Act. The scope of our FY 1994 work was not sufficient to enable us to express an opinion on HCFA's financial statements because significant matters, similar to the accounts receivable and payable issues discussed in this report, limited our ability to apply required audit procedures. As a result of these matters and the material effect on the accounts, we planned our work to audit only the FY 1995 combined statement of financial position and focused our work on following up on weaknesses that we previously identified.

Because of the matters discussed in the following paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express an opinion on the combined financial statements referred to above. We discussed a draft of this report with HCFA officials who generally concurred with the findings and recommendations. We have incorporated the officials' comments where appropriate.

REPORT ON FINANCIAL STATEMENTS

In accordance with the CFO Act, HCFA prepared the principal financial statements for FYs ended September 30, 1995 and 1994. These statements are the responsibility of HCFA's management, and include the accounts of all funds it administers: the hospital insurance trust fund, the supplementary medical insurance trust fund, Medicaid grants, and the administrative costs of these funds. We were not able to express an opinion last year on HCFA's FY 1994 financial statements [1] because significant matters, similar to the accounts receivable and payable issues discussed in this report, limited our ability to apply required audit procedures. As a result of these matters and the material effect of the accounts on the financial statements, we planned our work this year to audit only the FY 1995 combined statement of financial position.

Limitations on our ability to apply certain audit procedures required by Government Auditing Standards, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin 93-06, Audit Requirements for Federal Financial Statements, precluded us from expressing an opinion on HCFA's FY 1995 combined financial statements.

> ***Medicare Accounts Receivable.*** *We were again not able to apply sufficient audit procedures to satisfy ourselves as to the fair presentation of the reported Medicare accounts receivable balance of $3.2 billion at September 30, 1995. The internal controls over the processing of Medicare accounts receivable were still not adequate to reduce, to a low level, the risk that the accounts receivable balance could be materially misstated. It was also impractical for us, due to the lack of essential documentation, to extend our audit procedures sufficiently, to otherwise substantiate the account balance.*
>
> ***Medicare Accounts Payable.*** *The necessary documentation supporting the Medicare accounts payable balance of $22.0 billion was not made available for us to test the actuarial determination of the account balance. Nor did HCFA provide sufficient data to enable us to substantiate the accounts payable balance using alternative auditing procedures. However, from the limited information obtained, we identified a material internal control weakness related to the inadequate reconciliation of the actuarial estimate with actual claims data.*

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[1] Inspector General's Report on the Health Care Financing Administration's Combined Financial Statements, (A-17-94-03032), dated June 1995.

Medicaid Accounts Payable. *The HCFA did not record the Federal portion of Medicaid accounts payable amounts recorded in the States' records and/or financial statements. In our FY 1994 report, we noted that the Medicaid accounts payable balances recorded by the States could be billions of dollars. According to HCFA officials, the HCFA is exploring solutions as part of a Governmentwide Financial Statement Audit Task Force, and did not implement changes for FY 1995.*

Medicaid Accounts Receivable. *The HCFA did not record the Federal portion of Medicaid accounts receivable amounts recorded in the States' records and/or financial statements. In our FY 1994 report, we noted that the Medicaid accounts receivable balances recorded by States could be about a billion dollars. According to HCFA officials, the HCFA is exploring solutions as part of a Governmentwide Financial Statement Audit Task Force, and did not implement changes for FY 1995.*

Because of the significance of the matters discussed in the preceding paragraphs, and because we were not able to apply other auditing procedures to satisfy ourselves as to the fair presentation of the accounts involved, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the combined statement of financial position as of September 30, 1995 and 1994.

Consistency of Other Information. *We undertook the review of HCFA's combined statement of financial position for the purpose of forming an opinion on this statement which, as described above, resulted in a disclaimer of opinion. The presentation of the financial report includes an overview of operations and supplemental information, which are the responsibility of HCFA's management. This information has not been subjected to auditing procedures and, accordingly, we express no opinion on it.*

REPORT ON INTERNAL CONTROLS AND COMPLIANCE WITH LAWS AND REGULATIONS

The results of our tests of internal controls and compliance issues identified five reportable conditions,[2] of which two are material internal control weaknesses. The HCFA reported Medicare accounts receivable as a material weakness[3] under its Federal Managers' Financial Integrity Act (FMFIA) program.[4] We also identified a material internal control weakness related to Medicare accounts payable.

MEDICARE ACCOUNTS RECEIVABLE

For FY 1994 we reported that we were not able to apply sufficient audit procedures to satisfy ourselves as to the fair presentation of the reported Medicare accounts receivable balance. The lack of essential documentation by Medicare contractors prevented us from extending our audit procedures sufficiently to otherwise substantiate the account balance. In our final report, Report on the Health Care Financing Administration's Internal Control Structure Over Medicare Accounts Receivables for the Fiscal Year Ended September 30, 1994 (A-01-94-00520), dated August 1995, we recommended that HCFA (1) develop an approach to review and monitor the accounts receivable internal control structure that provides management reasonable assurance that adequate controls are present; (2) establish an integrated financial management system to promote consistency and reliability in recording and reporting accounts receivable information; (3) retain proper documentation to support the reported balances; (4) improve reporting controls to ensure that accounts receivable amounts are accurately summarized and valued at appropriate amounts; (5) develop control procedures to provide independent checks

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[2] *OMB Bulletin 93-06 defines a reportable condition as a matter coming to our attention related to a significant deficiency in the design or operation of the internal control structure that, in our judgment, could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.*

[3] *OMB Bulletin 93-06 defines a material weakness as a reportable condition in which the design or operation of one or more internal control structure elements does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.*

[4] *The HCFA reported "Medicare Contractor Accounts Receivable" and "Medicare Secondary Payer (MSP)" as material weaknesses. The MSP weakness includes establishing an awareness of accounts receivables.*

by management on the validity, accuracy, and completeness of the amounts reported to HCFA, including a reconciliation with the contractors' supporting documentation; (6) refine the financial reporting instructions to facilitate consistent and reliable contractor reporting; (7) receive training on what information is required and possible methods of obtaining and valuing the information; and (8) strengthen existing internal controls related to the segregation of duties, especially in the cash/checks receipts areas.

In response to our FY 1994 report, HCFA concurred with all eight of our recommendations. The HCFA indicated that since most of the FY 1994 recommendations address financial data maintained exclusively at the Medicare contractor sites, the following actions were taken in FY 1995 to assist the contractors in their reporting responsibilities; (1) a protocol was developed for Medicare contractors to perform self assessments of their internal control structure; (2) CFO seminars were conducted to educate Medicare contractors regarding the preparation of financial reports; (3) financial reporting instructions to the contractors were revised; and (4) Medicare contractors were instructed to retain proper source documentation to support the reported accounts receivable balances. In addition, the HCFA officials indicated that the Medicare Transaction System (MTS) is designed with a detailed integrated financial management system that will provide accounting data directly to HCFA's core accounting system.

Despite these improvements, HCFA has again declared its Medicare contractor accounts receivable area a material weakness for FY 1995 under the FMFIA. Moreover, HCFA also indicated that the FMFIA material weakness would not be corrected until 1999, when the MTS is planned to be operational. In commenting on our draft report, HCFA noted that MTS is designed, with participation by the OIG, to provide HCFA with an integrated financial management system to provide reliable financial data. Until an integrated financial management system is fully implemented, the risks remain high that there will not be consistent and reliable recording and reporting of accounts receivable information.

In order to assess control risk over the reporting of Medicare accounts receivables for FY 1995, we followed up on HCFA's corrective actions by participating in selected Contractor Performance Evaluation (CPE) reviews performed by HCFA regarding selected MSP operations. The MSP receivables represent about 15 percent of the $3.2 billion accounts receivable, net of an allowance for uncollectible accounts, reported at September 30, 1995. The CPE reviews found that internal control weaknesses identified in prior years' audits still exist. Although the CPE reviews noted some improvements, some contractors still have not: (1) maintained the necessary supporting documentation to substantiate the

amounts they reported to HCFA; (2) established an integrated financial management system to promote consistency and reliability in recording and reporting accounts receivable information; (3) developed control procedures to provide independent checks by management on the validity, accuracy, and completeness of the amounts reported to HCFA; (4) strengthened existing internal controls related to the segregation of duties, especially in the cash/checks receipts areas; and (5) improved their methodology for estimating the amount of the allowance for uncollectible accounts receivable to comply with applicable accounting principles.

As a result, the actions taken by the HCFA were not sufficient to correct the weaknesses reported last year and the lack of essential documentation by some Medicare contractors visited, continues to prevent us from extending our audit procedures sufficiently to otherwise substantiate the Medicare accounts receivable balance.

MEDICARE ACCOUNTS PAYABLE

In our FY 1994 report, we noted that the CFO Act requires an agency's chief financial officer to develop and maintain an integrated accounting and financial management system which complies with applicable accounting principles and provides for complete and reliable information. Sufficient documentation of this system should be made available to the auditors. We were not provided the documentation needed to support the actuarial determination of the Medicare accounts payable balance. In our prior report, we recommended that HCFA determine whether an alternative method based on the National Claims History File (NCHF) or Medicare contractors data would provide a better estimate for financial statement reporting.

In response to our FY 1994 recommendations, HCFA stated that the contractors were surveyed and it was determined that the current claims processing systems would require programming changes to compile payments by service dates needed to provide an accounts payable in a timely manner. HCFA officials indicate that resources were not available in FY 1995 to accomplish these standard system changes. However, HCFA believes that since its Office of the Actuary's (OACT) methodology is used to determine premium amounts, trust fund projections, and trust fund budgets, it should also be an acceptable method to determine benefits payable.

The OACT, which is responsible for developing the Medicare accounts payable balance using actuarial methods, again did not provide us with sufficient information of their process and other information necessary to test the FY 1995 accounts payable balance. For the past several years, HCFA has used the same methodology to determine the Medicare accounts payable estimate. For FY 1995, the actuarial estimate for Medicare accounts payable decreased from FY 1994 by $3.0 billion, however, Medicare benefit payments for FY 1995 increased by $1.2 billion from FY 1994. The OACT could not explain the reasons for these differences.

We attempted to perform other auditing procedures to substantiate the Medicare accounts payable balance by identifying claims where services were provided during FY 1995 but subsequently paid in FY 1996. One possibility which we explored was use of the NCHF to identify such claims and adjustment items such as pass through costs, outstanding checks, and prior year adjustments. Use of this detailed claims data, however, resulted in a $8.3 billion discrepancy from the $21.9 billion actuarially determined estimate. The HCFA officials could not explain the difference but did provide the OIG with detailed data on the NCHF in an attempt to reconcile the data to the actuarial estimate. In our opinion, the inability to reconcile the actuarial estimate with actual detailed claims data is a material internal control weakness.

We continue to be very concerned that the actuarial accounts payable estimate may not be accurate for financial statement reporting. We believe that another possible alternative would be to use detailed claims data from the Medicare contractors to estimate the accounts payable based on services provided in a year but subsequently paid in the following year. Although there are some obstacles to overcome with this technique, the result could be a more reliable accounts payable estimate until the MTS is fully implemented. According to HCFA officials, the MTS will provide accounting data to develop an estimate for Medicare accounts payable.

MEDICAID ACCOUNTS PAYABLE

For FY 1995, the Medicaid program financial results were reported on a modified cash basis which did not require the recording of an accounts payable due the States for the Federal portion of accrued expenses for Medicaid services rendered by health providers which have not been paid by the States. This included (i) claims for services that have been provided but not yet reported to Medicaid State agencies and (ii) claims for services that have been submitted to Medicaid State agencies but are in process. The Federal portion of the Medicaid accounts payable

balance was recorded in the records and/or financial statements with other Federal grant accounts payable data for the States we reviewed. However, the States were not required to identify the Medicaid portion of the accounts payable separately or report the amounts to the HCFA.

To strengthen the CFO Act requirements, the Federal Accounting Standards Advisory Board (FASAB) issued a Statement on the Accounting for Liabilities of the Federal Government, dated September 1995. This statement states that Medicaid payments should be recognized when they are due to health providers for services that have been rendered. The FASAB advises that the liability should be recognized in the period it occurs if the future outflow of resources is probable and the liability is reasonably estimable. The statement is effective for fiscal periods beginning after September 30, 1996. However, early implementation has been suggested by FASAB, GAO, Office of Management and Budget, and the Department of the Treasury. The HCFA argues that the Federal accounts payable is not due to the health providers but rather to the State as they actually incur expenditures for their payments to the health providers.

In our FY 1994 report, we noted that financial information gathered from eight States disclosed that all had included in their financial records and/or financial statements (i) an accounts payable amount that included Medicaid claims for services that had been provided but had not been reported to the Medicaid State agency and claims in process that had not been paid, and (ii) an asset amount for the estimated Federal portion the States expected to receive from HCFA for their Medicaid accounts payable. We found that one State specifically identified the Medicaid amount in its financial statement accounts payable balance, however, most did not. Our limited review indicated that the Medicaid accounts payable balance recorded by States could be billions of dollars.

As mentioned above, the FASAB did issue the Statement on the Accounting for Liabilities of the Federal Government that clearly states that Medicaid payments should be recognized when payments are due and payable to health providers. The footnotes to HCFA's FY 1995 financial statements indicate that HCFA is pursuing, through its participation in the Single Audit Sub Group of the Governmentwide Financial Statement Audit Task Force, a method to validate Medicaid program liability. In addition, HCFA officials indicate that methods to gather data without burdening the States with additional reporting will also be pursued. We continue to believe that the Federal portion of Medicaid accounts payable recorded on States' records and/or financial statements should be included in HCFA's combined statement of financial position. Although FASAB requirements are not effective until FY 1997, HCFA needs to start developing policies and procedures to ensure

effective and complete implementation by FY 1997. If such policies and procedures are not implemented, this issue could be a material internal control weakness in the future.

MEDICAID ACCOUNTS RECEIVABLE

In FY 1995, the HCFA reported the Medicaid program financial results on a modified cash accounting basis which did not record the Federal share of Medicaid accounts receivable owed to State agencies by providers, drug manufacturers, insurance agencies, beneficiaries' estates, and other sources. Collections of Medicaid receivables were reported as refunds or offsets by the States on their Medicaid quarterly expenditure reports. The Federal portion of Medicaid accounts receivable was recorded on the records and/or financial statements with other Federal grant accounts receivable data for the States we reviewed. However, the States were not required to identify the Medicaid portion of the accounts receivable separately or report the amounts to the HCFA.

The CFO Act requires complete, reliable, and timely financial information and provides a Federal agency's chief financial officer with the authority to obtain required information from States. To strengthen the CFO Act requirements, OMB issued the Statement of Federal Financial Accounting Standards Number 1, Accounting for Selected Assets and Liabilities. This standard states that "a receivable should be recognized when a Federal entity establishes a claim to cash or other assets against other entities . . . If the exact amount is unknown, a reasonable estimate should be made."

In our FY 1994 report, we noted that most of the seven States reviewed recorded Medicaid receivable data in their records. We also noted that many of the States included Medicaid receivable data in their financial statement receivable balance, although not specifically identified as Medicaid. In addition, the Federal portion of Medicaid receivables due to the Federal Government was included by two States in their financial statement balances, although not specifically identified as Medicaid. Based on this review, we reported that the Federal portion of Medicaid accounts receivable being recorded by States could be about a billion dollars each year.

As mentioned above, in our FY 1994 report, we recommended that HCFA obtain from the FASAB a standard of accounting for Medicaid accounts receivable, and apply this standard to the Medicaid program. We also recommended that HCFA,

if appropriate, determine the amount of Medicaid accounts receivable recorded at the State agencies and include the Federal share in HCFA's combined statement of financial position.

The HCFA did not receive a specific response from FASAB regarding the recording of Medicaid accounts receivable and payable and does not believe that it will. However, as mentioned above the OMB guidance indicates that a receivable should be established when there is a claim to cash or other assets. The footnotes to HCFA's FY 1995 financial statements disclosed this issue and that HCFA is participating in the Single Audit Sub Group of the Governmentwide Financial Statement Audit Task Force to review possibilities to determine the materiality of these receivables. The HCFA also indicated that the Single Audit Sub Group will review methods to gather and validate Medicaid program receivables without burdening the States with additional reporting. We continue to believe that the Federal portion of Medicaid accounts receivable recorded on States' records and/or financial statements should be included in HCFA's combined statement of financial position.

FINANCIAL REPORT OVERVIEW

In response to our FY 1994 recommendation that HCFA develop performance indicators for the Overview, HCFA concurred and expected a set of performance measures for major program areas to be presented to the planning committee for approval during the fall of 1995. Once accepted by the committee, HCFA planned to present the measures to their customers to secure their input. The HCFA's FY 1995 financial report included a discussion of its goals and critical indicators that defined its mission. Although performance measures were not included in the FY 1995 Overview, HCFA has begun accumulating data to develop performance measures but it does not expect that public reporting will likely occur until FY 1996.

We continue to believe that without specific program performance measures, the Overview does not provide information necessary to determine whether HCFA's programs are achieving their mission and intended results.

RECOMMENDATIONS

Because the actions taken by HCFA have not sufficiently corrected the weaknesses reported last year, we continue to recommend that HCFA implement our FY 1994 recommendations. In addition, we recommend that HCFA report the lack of

procedures requiring the reconciliation of the actuarial Medicare accounts payable estimate with actual claims data as a material weakness in HCFA's annual FMFIA report.

MANAGEMENT'S RESPONSIBILITIES

The HCFA's management is responsible for designing and maintaining an internal control structure that provides reasonable, but not absolute, assurance that (1) transactions, including those related to obligations and costs, are executed in compliance with applicable laws and regulations; (2) funds, property, and other assets are safeguarded against waste, loss, and unauthorized use or misappropriation; (3) transactions are properly recorded and accounted for to prepare reliable financial statements; and (4) data that support related performance measures are properly recorded and accounted for to permit preparation of reliable and complete performance information.

AUDITOR RESPONSIBILITIES AND METHODOLOGIES

Our responsibilities are to (1) plan our work to include the combined statement of financial position; (2) report the results of our review of HCFA's internal control structure to the extent that its inadequate design or ineffective operation, if applicable, could materially affect HCFA's combined statement of financial position; (3) report the results of our tests of HCFA's compliance with applicable laws and regulations that could materially affect the combined statement of financial position; and (4) obtain an understanding of the internal control structure policies and procedures and assess the control risks applicable to HCFA's reported performance measurement data.

Our tests of applicable internal controls and compliance were performed to determine the extent of our procedures necessary for expressing an opinion on the combined statement of financial position and to report findings resulting from our control and compliance testing. We do not express separate opinions about the adequacy of the internal control structure or compliance with laws and regulations.

Because of inherent limitations in any internal control structure, losses, noncompliance, or misstatement may nevertheless occur and not be detected. Also, projection of any evaluation of the internal control structure to future periods is subject to the risk that controls may become inadequate because of changes in conditions or that the degree of compliance with controls may deteriorate. Our consideration of the internal control structure would not

necessarily disclose all matters in the internal control structure that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses.

To fulfill these responsibilities we:

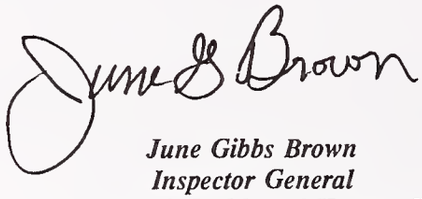
- *Obtained an understanding of HCFA's internal control structure policies and procedures and assessed the control risks.*

- *Evaluated the operation or the relevant internal control structure policies and procedures designed by management to provide reasonable, but not absolute, assurance that the above management objectives were met for the following significant cycles, classes of transactions, and account balances:*

  - *Medicare Accounts Receivable*
  - *Medicare Accounts Payable*
  - *Medicaid Accounts Receivable*
  - *Medicaid Accounts Payable*
  - *Financial Reporting*

- *Tested compliance with selected provisions of the following laws and regulations that may materially affect the statement of financial position or are specified in OMB Bulletin 93-06:*

  - *Social Security Act, as amended*
  - *CFO Act of 1990*
  - *FMFIA of 1982*



June Gibbs Brown
Inspector General
Department of Health and Human Services

June 18, 1996

GLOSSARY

Actuarial Soundness: A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.

Administrative Costs: General term that refers to Medicare and Medicaid administrative costs, as well as HCFA administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-HCFA administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. HCFA administrative costs are the costs of operating HCFA (e.g. salaries and expenses, facilities, equipment, rent and utilities, etc). These costs are reflected in the Program Management account.

Beneficiary: A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an "enrollee").

Benefit Payments: Funds outlayed or expenses accrued for services delivered to beneficiaries.

Carrier: A private business, typically an insurance company, which contracts with HCFA to receive, review, and pay physician and supplier claims.

Cost-Based Health Maintenance Organization (HMO/Competitive Medical Plan, CMP): A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

Demonstrations: Projects and contracts that HCFA has signed with various health care organizations. These contracts allow HCFA to test various or specific attributes such as payment methodologies, preventive care, social care, etc., and to determine if such projects/pilots should be continued or expanded to meet the health care needs of the Nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

Discretionary Spending: Outlays of funds subject to the Federal appropriations process.

Disproportionate Share Hospital (DSH): A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Durable Medical Equipment (DME): Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Expenditure: Expenditure refers to budgeted funds actually spent. When used in the discussion of the Medicaid program, expenditures refer to funds actually spent as reported by the States.

Expense: An outlay or an accrued liability for services incurred in the current period.

Federal General Revenues: Federal tax revenues (principally individual and business income taxes) not earmarked for a particular use.

FICA (Federal Insurance Contribution Act) Payroll Tax: Medicare's share of FICA is used to fund the HI Trust Fund. In FY 1995, employers and employees each contributed 1.45 percent of taxable wages, with no limitations, to the HI Trust Fund.

FMAP (Federal Medical Assistance Percentage): The portion of the Medicaid program which is paid by the Federal government.

FMFIA (Federal Managers' Financial Integrity Act): A program to identify management inefficiencies and areas vulnerable to fraud and abuse and to correct such weaknesses with improved internal controls.

Health Care Prepayment Plan (HCPP): A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services) whether provided by its own physicians or its contracted network of physicians. If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

High Risk Area: A potential flaw in management controls requiring management attention and possible corrective action.

Hospital Insurance (HI): See "Part A."

Intermediary: A private business, typically an insurance company, which contracts with HCFA to receive, review, and pay hospital and other institutional provider benefit claims.

Internal Controls: Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment.

Mandatory Spending: Outlays for entitlement programs (Medicare and Medicaid) that are not subject to the Federal appropriations process.

Material Weakness: A serious flaw in management controls requiring high-priority corrective action.

Medicare Contractor: A collective term for carriers and intermediaries.

Medicare Trust Funds: Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

MR/UR (Medical Review/Utilization Review): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

MSP (Medicare Secondary Payer): A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

Obligation: Budgeted funds committed to be spent.

Outlay: Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the States for Medicaid benefits.

Part A: Medicare Hospital Insurance, also referred to as "HI."

Part B: Medicare Supplementary Medical Insurance, also referred to as "SMI."

Payment Safeguards: Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, MR/UR, provider audits, and fraud and abuse detection.

PRO (Peer Review Organization): PROs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

Productivity Investments: Spending aimed at increasing contractor operational efficiency and productivity through improved work methods, application of technology, etc.

Program Management: HCFA's operational account. Program Management supplies the agency with the resources to administer Medicare, the Federal portion of Medicaid, and other Agency responsibilities. The components of Program Management are: Medicare contractors, survey and certification, research, and administrative costs.

Provider: A health care professional or organization providing medical services.

Recipient: An individual covered by the Medicaid program, however, now referred to as a beneficiary.

Risk-Based Health Maintenance Organization (HMO)/ Competitive Medical Plan (CMP): A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk-HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

Revenue: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

SECA (Self Employment Contribution Act) Payroll Tax: Medicare's share of SECA is used to fund the HI Trust Fund. In Fiscal Year 1995, self-employed individuals contributed 2.9 percent of taxable annual income, with no limitation.

State Certification: Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

Supplementary Medical Insurance (SMI): See "Part B."

Tax and Donations: State programs under which funds collected by the State through certain health care related taxes and provider-related donations were used to effectively increase the amount of Federal Medicaid reimbursement without a comparable increase in State Medicaid funding or provider reimbursement levels.

HCFA FINANCIAL REPORT READER SURVEY

Please help us evaluate the usefulness of this report to our readers and improve future reports by completing this survey and returning it to:

HCFA Financial Report Survey
C3-02-07
7500 Security Blvd.
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Please circle the appropriate rating, with 10 being the most favorable rating:

Administrator's Message	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
CFO Message	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Strategic Plan	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Medicare	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Medicaid	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Managed Care	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Financial Statements	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Notes	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Supplement	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Format	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Graphs	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Overall	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**

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